



*student
health*

A PUBLICATION OF THE CHICKERING GROUP

SPECTRUM

LEADERSHIP FORUM
EDITION

FEBRUARY 2006

COLLEGE HEALTH 2010

College Health 2010

ELEANOR W. DAVIDSON, MD, CASE UNIVERSITY

Ninth Leadership Forum:

Student Health 2010: What Changes Will the Next Five Years Bring?

STEPHEN C. CAULFIELD, MSW, THE CHICKERING GROUP

The Future of the Health Care System in the United States

DREW E. ALTMAN, PhD, HENRY J. KAISER FAMILY FOUNDATION

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SACRED BODISON, MD, MBA, UNIVERSITY OF MARYLAND



College Health 2010

Returning each year to the Leadership Forum, I find an opportunity to engage in lively dialogue with colleagues I've come to value highly. We share problems and challenges, debate new approaches, and find a sense of community that helps us continue our work.

After this year's Forum, how do I envision College Health in 2010?

Our major responsibility will continue to be *caring for students*.

As the outward appearance of this care may change, it continues to include:

1. Public health elements
2. Direct patient care (physical and mental)
3. Education
4. Advocacy

How students access care shifts each and every year, as **Larry Moneta** and **Bill Purdy** point out. E-mail contact (formerly a subject for debate, but now here to stay) allows us to reach students before they ever come to the Health Service:

- Information on our websites gives students an idea of the kinds of things they can see us about (beyond sore throats and coughs);
- The ambivalent student can 'test the waters' with a question or e-mail contact before coming in person to see us;
- Health education and information, so important in every contact with students, can be directly accessed from national resources such as cdc.gov and nlm.nih.gov (we have links to these websites on our electronic medical record);
- Communication can give students access to care and advice 24/7 — advice which is tailored to their specific needs (quite different from an ER or urgent care source).

As Don Berwick pointed out in *Escape Fire*, "The access we need to create is access to help and healing, and that does not always mean...reliance on face-to-face meetings."

And yet these face-to-face meetings (when students

come to the Health Service) can never be neglected or undervalued — though they are easy to misconstrue. I first learned this 20 years ago when our service was trying out a cold self-care program. Students complained bitterly about what they saw as advice to go take care of themselves and "be well." When they came to us, they wanted someone to take care of them.

I was curious what made students seek care for colds (something they teach you how to treat on television, after all) and found recurring patterns. Often, a sore throat is a 'ticket of admission' — something everyone knows you can take to a doctor or nurse. Like a headache or a stomachache, it can simply mean "I don't feel right." Our job is to figure out why. A surprising number of students with "minor illness" have lost a parent in childhood.

If we try to eliminate these visits for minor ailments or triage them to self-care, we miss opportunities to say:

- When you feel bad, we want to see you.
- It's okay if you're not clear about what's causing you to feel badly; we'll help you figure that out.

If the distress is psychological but the symptoms are in the body, we want the student to come see us — not worry that the illness seems too insignificant at first.

Further, as Aaron Black from the University of Rochester has pointed out (in his 1998 ACHA talk on contemporary trauma therapy): In normal development, an individual needs to get a sense of self as "worthy of care, given by others." What message do students receive if we turn them away when their symptom is "too small" or when we tell them they wouldn't be sick at all if they just took better care of themselves? What costs, direct and indirect, are the consequences of that kind of policy? (Might Elizabeth Shin have returned to the Health Service?)

Mental health care will continue to be a fundamental component of our service, both within the Health Service and also in the Counseling Service. Each setting has unique and valuable characteristics. Hopefully, many schools will continue to offer both these models of access for students. Rather than creating a single, unified model of mental

health care, we need to offer care and access that is complementary, collaborative, and as varied as our diverse student bodies.

Psychiatrists will have a role both within the Counseling Service and also in the Health Service. The Health Service can function as a 'home base' for students, and specialized services will be available within the Counseling Service. The psychiatrist will need to provide comprehensive back up to the clinicians in the general clinic, as well as education and continued training, in order to expand this resource. The Counseling Service constantly reevaluates what services they offer, how much, and to whom.

In our 21st century global environment, as **Ed Ehlinger** points out, we cannot overlook the importance of public health functions. The threat of bird flu or other pandemics make us all reexamine our resources and planning. Continuing education and training needs to prepare our staff, not for a single role, but for many

roles that will change as new scientific information becomes available.

Finally, we need to remain personally flexible and willing to look at old problems in new ways. As Case University's President, Ed Hundert, has written, "We need to provide a powerful environment that challenges conventional wisdom, to ensure that our future generations can see things not for what they are but for what they can become."

Note:

1. Berwick, Donald M., MD. *Escape Fire: Designs for the Future of Health Care*. Jossey-Bass 2003, pg. 203.



Eleanor W. Davidson, MD
Director University Health Services
Case University

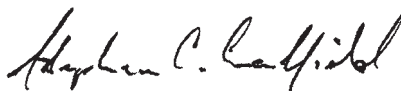
Editor's Note

The last issue of *Spectrum*, "Health Education and Health Promotion: Primary Prevention and Student Health," generated more comments than we usually receive. Most were very positive, such as, "The best and most comprehensive case for health education we have seen." Some, however, expressed concern that the issue was unbalanced, assigning too much importance to primary prevention in areas such as alcohol abuse, where there is little evidence of effective primary prevention, and too little importance to the balance between providing good, direct health care and promotion of healthy lifestyles.

All this leads us to repeat something we said almost 10 years ago when we started to publish *Spectrum*. Our intention has always been to publish articles which meet three criteria: they are topically relevant; they represent an informed opinion; and they are readable. We have never

aspired to be a refereed journal of scientific research. The *Journal of American College Health* does this very well.

Four years ago, we expanded *Spectrum*, added outside editors and focused each issue on a topic. Our hope is that *Spectrum* will become, for the 8,000 people who read it, what the Leadership Forum is for Nell Davidson, "An opportunity to engage in lively discussion ...share problems and challenges, debate new approaches, and find a sense of community that helps us continue our work."



Stephen C. Caulfield, MSW
Chairman
The Chickering Group

Ninth Leadership Forum: Student Health 2010: What Changes Will

Stephen C. Caulfield, MSW, The Chickering Group

Editor's Note: In November, 2005, 45 student health leaders, representing 41 campuses, from 24 states and the District of Columbia, with responsibility for the health care of over 700,000 students, met in two locations to discuss "Student Health 2010: What Changes Will the Next Five Years Bring?"

Both the present and future of college health are determined by multiple factors: health care and the health economy; public health; the current generation of students with their behaviors, risk factors, and underlying morbidity; their parents and their relationships with their college students, and their expectations for student health; and, of course, higher education in general and, particularly, the specific traits and traditions of each campus.

Underlying these five "forces" are the rapidly changing environments of electronic communications and technology; the financing of health and higher education; the national economy and employment opportunities; and a myriad of geopolitical issues from the environment to terrorism and war.

This summary of the Leadership Forum's participants' views on college health five years hence will somewhat artificially group their thoughts and opinions into these "environmental factors." We will conclude with the participants' sense of where college health will be in 2010 and why the anticipated changes are likely to occur.

Integration of Student Health

"We are developing an integrated Health and Wellness Residential Learning Community. It will be co-lead by our Director of Health Promotion and a representative of the academic faculty from our College of Nursing & Health Sciences. There will be approximately 120 students all living together, sharing goals of promoting healthy lifestyle choices. Student will be able to attend academic courses as well as attend programs and activities in their residence hall."

Estelle Maartmann-Moe, APRN, University of Vermont

"I agree that our mission is increasingly extending beyond the walls of our Health Services facilities, as we expand our campus public health role. For example, we are taking a lead role in engaging the campus community in considering how

to increase support and reduce risk for students with mental health concerns. With campus partners, we are reviewing campus policies and protocols as they relate to student welfare, and are working to improve front-line identification and referral of students in distress."

Janet Corson-Rikert, MD, Cornell University

"Integration of health is also a theme at Columbia's Medical Center Campus. First, our strategic planning process emphasizes coordination of administrative, clinical and outreach/educational efforts including curriculum infusion — for example, developing a course such as Health Insurance 101, since so many of our health sciences students are very uninformed about health financing. We also plan to position ourselves not simply as providers, but also as advocates for our students in all aspects of the Medical Center — adequate fitness facilities, improved eating options, and an adequate physical space to provide care."

Polly Wheat, MD, Columbia Medical

More Demand, Sicker Students

"Current University students are clearly sicker than the University students of five years ago and the demand for behavioral health services has gone up significantly."

John Andrews, MD, MPH, University of Cincinnati

"Students are now able to enter college with disease burdens that would have prevented their attendance even a few years ago. We have students who have cystic fibrosis, are HIV positive and who have many other significant health problems. This challenges us to know much more medicine than the primary care associated with healthy students. This trend is going to continue. In five years time, the number of students with significant disease will be even greater."

Sacred Bodison, MD, MBA, University of Maryland

"Beyond those with serious disease, we are seeing many manifestations of increased anxiety. On a year-over-year basis, our weekly visits to the Student Health Service are up by about 35%, from 375 visits a week this year, compared

the Next Five Years Bring?

with 275 a year ago. Much of this increase I attribute to anxiety, depression and general distress.”

Nell Davidson, MD, Case University

More Alcohol and More Violence

“We are observing a substantial increase in students seeking treatment as a result of acts of violence. Only a few years ago this would have happened only two or three times a year. We feel it is linked to a combination of fewer coping skills, little experience in conflict resolution, and little experience in community living. Alcohol is also a large part of this. Last year, through October, we had 36 hospital admissions for acute alcohol intoxication. This year we have had 76 admissions.”

Isabel Goldenberg, MD, George Washington University

“We too, have observed an increase in both alcohol abuse and violence. The most significant manifestation is in the increase in sexual assaults.”

Estelle Maartmann-Moe, APRN, University of Vermont

More Information, Less Privacy

Despite the privacy protections of HIPAA, several participants expressed concerns that genetic testing, and large medical and insurance databases could erode the community rating for insurability and lead to risk profiling.

“I don’t think it is unreasonable to see the end of community rating with genetic profiling. You are already seeing this in life insurance. You are seeing risk profiling using insurance claims data. You are seeing denials of coverage for people who are HIV positive. The concept of the social good is diminishing. As Steve Balmer at Microsoft said, ‘There is no such thing as confidentiality, get over it.’”

The following participants contributed these comments:

William A. Christmas, MD, FACP

Ronald Elson, MD, University of California, Berkeley

Ira Friedman, MD, Stanford University

Kathleen Golden-McAndrew, MSN, APRN, BC, ANP,
University of Massachusetts/Boston

Todd Holcomb, Iowa State University

Gail Moses, MD, College of William and Mary

Alastair Smith, MD, San Francisco State University

So against these broad, introductory themes of integration, increased demand and sicker students, more alcohol-related events including violence, and the tension between more information and less privacy, the group reflected on those environmental factors which would shape the future of college health.

Trends in Health Care

“Health care costs will continue to rise. Physician practices will consolidate and become more institutionalized, many becoming affiliated with hospitals, often teaching hospitals. This will result in higher overhead with the added cost burden of the hospital setting. Patients, our students among them, will migrate to teaching hospital settings for out-patient physician care and their associated higher cost structure.”

Polly Wheat, MD, Columbia Medical

“This trend will be compounded by extreme sub-specialization which will both add to costs and make the process of referral much more challenging both for the physician and the patient.”

Isabel Goldenberg, MD, George Washington University

“I sit on the board of a local IPA. We are observing four trends in health care:

- *Health plans are consolidating.*
- *HMOs are being replaced by PPOs.*
- *Health insurance plans are targeting high frequency chronic conditions about which there is consensus on management (e.g. hypertension, diabetes) and are paying for performance.*
- *There is increasing interest in data on frequency, cost and outcomes for various procedures — the so-called transparency of health information.”*

Ronald Elson, MD, University of California, Berkeley

“The trend toward pay-for-performance will be facilitated by a

“Current University students are clearly sicker than the University students and the demand for behavioral health services has gone up significantly.”

good Electronic Health Record (EHR). Groups of patients with similar disease burdens can be easily identified and tracked.”

William A. Christmas, MD, FACP

“A counter-balance to the rising cost trend will be the fact that the Federal government now pays for more than 50% of care and that will rise as the population ages and becomes Medicare eligible. So we are moving toward a single-payer system. Unfortunately, a near term corollary will likely be cost-shifting from Medicare and Medicaid to non-governmental payers, which will put more cost pressures on employer-sponsored plans, making parental coverage for students more limited.”

Greg Moore, MD, MPH, University of Kentucky

“And as health costs continue to rise, employers are going to look for ways to reduce their burden. The decision in October to cut GM’s retiree health is likely to mean that other employers will make similar reductions. The result will be more uninsured and underinsured over the next five years, and some portion of those will be our students.”

Bill Purdy, MD, Duke University

“Another cost-shifting mechanism will be the high-deductible health plans. Students who have parental coverage with as much as a \$2,000 deductible will likely defer necessary health care, with students from families who have fewer financial resources being particularly vulnerable.”

Janet Corson-Rikert, MD, Cornell University

“With individuals facing more and more out-of-pocket costs, we’re seeing places like CVS putting nurse practitioners in their stores to provide primary care. They call them ‘clothes on’ visits and I suspect this trend will spread much more rapidly than the walk-in clinics, the so called ‘Doc-in-a-Box’, of years past. A natural question for those campuses with a CVS nearby is, are these options going to be more attractive to some students than the Student Health Service?”

Bill Purdy, MD, Duke University

“That kind of convenience may well be attractive to students. I work with enough medical students and residents to understand that they are defining their work life in terms that are not consistent with consumer demand, so much so that I think access to care on nights

and weekends will be a growing challenge for everyone.”

Susan Even, MD, University of Missouri

“Not only are there changes in medicine’s work ethic, but also, more fundamentally, in medicine’s intellectual independence. I grew up understanding that medicine was a secular profession. I am now very concerned that religious values and religious politics may change how we practice. We are already seeing this in the FDA’s approach to emergency contraception. This all raises a fundamental question about the role of religion and of political influences at the intersection of science and government.”

Ira Friedman, MD, Stanford University

“If costs and cost-shifting are a likely major trend in health care, it seems likely there will also be a rise in health care consumerism. It is obvious to those of us who work in health sciences campuses that our students, medical, nursing and other health professions, are not only quite uninformed about health care financing, but also how to make health care decisions. So, too, are the patients. This implies a need for major efforts in health consumer education.”

Polly Wheat, MD, Columbia Medical

“Certainly one place consumers need education is regarding prescription drugs. Marcia Angell’s The Truth about the Drug Companies raises important questions about the pharmaceutical industry’s involvement in continuing medical education (CME), direct-to-consumer advertising (DTC), and patient education. Dr. Angell opens her chapter on ‘Marketing Masquerading as Education’ with the comment, ‘No one should rely on a business for impartial evaluation of the product it sells.’ What do we need to do about this with our student patients and their expectations for prescriptions for everything?”

Nell Davidson, MD, Case University

“Another theme in health care and consumer education is complexity. There is a lot of talk about ‘transparency’ of health data and information. But just consider Medicare, Part D, the new prescription drug plan. In most states there are 35-50 different plan options. Even people like ourselves, who are supposed to understand these things, are bewildered by this information.”

Polly Wheat, MD, Columbia Medical

“The larger health system, including our students, has been ‘taught’ by direct-to-consumer advertising that when ‘things are not right’ there is always a better state available. And the way to achieve that ‘better state’ is through the health care system and the pharmaceutical industry. This increase in consumer demand will be significant feature of the health economy going forward.”

Janet Corson-Rikert, MD, Cornell University

“Another major trend in health care will be internationalization, both on the demand side and the resource side. SARS is a good example on the demand side. On the resource side, ability to digitally transmit images and data for medical review to remote locations may mean some of the professional component of medicine can be done in India, Australia, or elsewhere. And even directly delivered health care may be provided off shore. As patients become more responsible for paying for their care, they may become quite willing to travel internationally to get higher quality and lower cost care.”

Ira Friedman, MD, Stanford University

The consensus among participants was that the health care financing and delivery system would be characterized by increasing costs, greater cost shifting from public payers to employer-sponsored plans and from employer-sponsored plans to individuals. This cost-shifting may be accelerated by high-deductible plans (consumer-directed health plans). The delivery system will be characterized by physician practice consolidation around hospitals, often teaching hospitals, raising practice overhead. Specialization and sub-specialization will continue, at the expense of primary care practitioners. Some professional components of health care will be available in lower-cost markets, both through telemedicine and patients traveling for care. Direct-to-consumer (DTC) advertising by the pharmaceutical industry will continue to increase demand for health care and prescription drugs. Efforts to reduce medical errors and practice pattern variation will include collection and publication of practice data, the so-called ‘transparency’ movement in health information.

State Medicaid programs will become more variable as states successfully apply for and receive waivers to alter their programs, making health insurance for the poor and near poor more uneven from state to state.

Likely Characteristics of the Public Health Environment in Next Five Years

“We are likely to see the trend of the past several years continue into the future, with increasing public health attention directed toward infectious threats, both natural and terrorist. We have all devoted significant resources to planning for anthrax, SARS, smallpox and now avian flu. With our international students and world-traveling students and faculty, both our campus and community colleagues are likely to look to us to play a central community public health role.”

Janet Corson-Rikert, MD, Cornell University

“The public health model focuses on three areas: monitoring, response, and primary prevention and health education. I agree with Janet that the emphasis on the pandemic threat has shifted focus to the first two, monitoring and response, although efforts to develop and distribute vaccines are very high. What strikes me as an opportunity for Student Health is our potential role in all of this: our public health response may be a key to our visibility and credibility both on one campus and in our communities going forward.”

Evelyn Weiner, MD, University of Pennsylvania

“On our campus it is similar, but the expectation is that we will also be externally focused and manage the partnership with our local and state public health agencies.”

J. Robert Wirag, HSD, University of North Carolina

“Public health in the U.S. responds to political influences. For example, health departments may receive significant payments from the Department of Homeland Security for work on bioterrorism and pandemics, but the basic public health surveillance and prevention programs are being neglected. Funding programs in response to the fear of the moment is not a thoughtful or comprehensive public health program.”

Sarah Van Orman, MD, The University of Chicago

“I agree. It feels like the public health system is broken with budget cuts in many of the basic prevention programs.”

Gail Moses, MD, College of William and Mary

“On the positive side of Homeland Security and Public Health, at least they have reopened lines of communication

again. I certainly feel better about our ability to mobilize quickly in a public health emergency.”

Susan Quinn, RN, Santa Rosa Junior College

“A danger is that many communities look to large universities as a resource for managing pandemics — we have dormitories, food services, stadiums and health services. Without explicit planning, they cannot rely on our resources. Who knows what our students will do? Will most go home? We may have a plan for Health Service staff, but what about our food service workers, building and grounds? What campuses will look like in the face of a real pandemic is largely unknown.”

Thomas Nary, MD, Boston College

“If we do experience a pandemic, we will quickly cross that threshold of treating people without seeing them. The intervention of choice in a pandemic will be isolation. ‘If you are sick, stay home.’ Although telephonic and e-mail treatment will be easier because we, presumably, know the diagnosis, it still will represent a fundamental change in the practice of medicine. The good news here is that college health may be far better positioned to manage care electronically than other parts of the delivery system.”

Michael Huey, MD, Emory University

“In the event of an infectious disease outbreak in the magnitude of a pandemic flu, the entire campus community will be affected. If your university is not a part of an academic medical center, your Health Center, even if it does not normally treat faculty and staff, will be a resource for health information and possibly services.”

Julia Bonner, MD, University of Wisconsin/Milwaukee

“Increasingly, public health is about communicating at all levels. Part of any good public health organization is its ability to have plans and procedures so that it will know what it wants to communicate, to whom it wants to communicate, and when it wants to communicate. In college health, a part of our public health responsibility will be to communicate both internally and externally. We must know, at a high level of detail, what we will do and how we will do it when the threat of a pandemic is real.”

John Andrews, MD, MPH, University of Cincinnati

In summary, the public health environment will be

focused on planning for a pandemic. This will pass through directly to Student Health Services and to the broader resources of the campus. Clear communication lines, clear and well understood decision authority, and highly specific action plans will be essential.

Changes in Student Population Over Next Five Years

“Our students today come from what I call ‘The Fragile Generation’. They have not learned conflict resolution through unsupervised play, and in many ways they have limited social skills. Technology is making this worse. Cell phones and instant messaging maintain contact with those friends and families elsewhere, not those who are present. In college, the students often find they cannot deal with conflict and are often anxious about social situations – anxiety they often treat by multiple shots of vodka before they head out the door.”

Greg Moore, MD, MPH, University of Kentucky

“I feel as though I run one of the largest residential treatment centers in Texas. When we count up our students who present with ADD, depression under current treatment, panic disorders, and those who have had a suicide attempt, we are at about 20% of our student body. Since these statistics are self-reported, we have to assume they are under-reported. If this demand grows, as we assume it will, how will we manage the increased demand? At TCU we are clear this not just a Student Health problem, but an issue the entire institution must address.”

John Terrell, MD, Texas Christian University

“We anticipate demand for behavioral health will continue to grow. We see students of the future living in technologically enhanced isolation. When they are introduced to the social fabric of the university they lack some of the basic person-to-person communication skills which clearly contributes to their stress and anxiety. Add to that indecision about career goals and life choices, you are likely to see much more demand for counseling and psychological services. This is consistent with the University’s mission to help these students succeed.”

Todd Holcomb, Iowa State University

“Technology may not be an impediment to developing social skills; it may be that students are developing social skills

which are just different from ours. Perhaps it is we who need to become more adaptive.”

Jim Yankech, University of Nebraska, Lincoln

“I agree. Certainly, in my practice with students, I welcome those times when an anxious student in my exam room calls a parent on their cell phone to discuss my diagnosis and proposed treatment plan. It saves me time and provides some assurance that treatment will be followed. I, of course, must carefully honor confidentiality in this process. One thing is sure: Students over the next five years will rely more and more on technology for every aspect of their lives. We must learn that e-mail is a valid way to provide and receive information in a prepaid health system, which is what most of student health is.”

Ralph Manchester, MD, University of Rochester

“I am quite astounded by the content of e-mails we get from students, if not the first time, certainly after two or three exchanges. This is the students’ preferred medium and to use it reduces many barriers to access.”

Carlo Ciotoli, MD, New York University

“Our students’ reliance on e-mail as their communication of choice creates a significant non-visit demand on our time scheduling in Student Health. It is a very legitimate use of a clinician’s time to respond to these e-mails, but our traditional view of what a productive clinician does is measured in visits. We have to modify this.”

Suman Kashyap, MD, Michigan State University

“Students today are demanding and, my guess is, may be more so in the next five years. So much of what they do each day reinforces their expectation of instant or very rapid response or resolution. They expect to get Health Center appointments with the same online efficiency they can get concert tickets.”

J. Robert Wirag, HSD, University of North Carolina

“They do demand service, but these are the same kids who were driven to and from playdates, to soccer, to piano lessons, and everywhere else without having to organize any of it for themselves. So we have students who are expecting the University to continue to program their lives. The result is they are both demanding and dependent.”

Bill Purdy, MD, Duke University

“Which puts those of us in higher education back into the ‘in loco parentis’ role. But it is now seen differently from a generation ago, where adult supervision and oversight was the expectation. We now are being looked to as replacements for ‘snowplow’ parents, who clear the way for every decision and every activity.”

Glen Egelman, MD, Bowling Green State University

“Perhaps it is my perspective from the community college population, but I am seeing more and more people without health insurance. What is evolving is a whole culture of looking to the ‘street’ for health care, not just the sharing of prescription drugs we just saw written up in The New York Times, but medical advice from untrained lay people and self-diagnosis and treatment from the Internet.”

Susan Quinn, RN, Santa Rosa Junior College

“As the social fabric of the country fails segments of the population — lost jobs and health insurance — some of those affected will become students. These older students will use their student status for community, housing, medical care, and health insurance. These older students will create a disproportionate burden on those students who are there primarily for education.”

Margo Amgott, Columbia University

The consensus among participants was that the student body of 2010 will enter college from a programmed and protected childhood and adolescence. In the face of real competition, substantially less structured communal living arrangements, and career and employment uncertainty, students will be anxious, demanding, and have limited coping and conflict resolution skills. More students will achieve admission to college with significant disease burdens. All will be technologically facile, with e-communications the media of choice. Alcohol abuse and ‘pharming’ — the self-directed practice of sharing prescription drugs, will be the mainstream of self-care for anxiety and depression. The number of older students will increase.

The Characteristics of the Parents of the Students of 2010

“Parents have recently become much more involved in the process of getting their kids into college. They hire coaches,

“Our challenge is how well do we help parents, students, and ourselves changing environment as students bounce back from various problems?”

placement consultants, pay for exam preparation courses and are more directly involved in the actual applications. It's no accident that they are more involved once their child is accepted. Is this going to change in the next five years?”

Ronald Elson, MD, University of California, Berkeley

“Not much. Many parents fear their children will not be as successful as they have been. But not every school has the same population of students. At SFSU, 38% of our students graduate in six years. Our challenge with both students and parents is to facilitate a student's progress at a pace that is appropriate to their situation.”

Alastair Smith, MD, San Francisco State University

“Parents over the next five years will have fewer financial resources and increasing personal debt. This will make the cost of higher education a much more significant issue. There will also be more first generation college students, whose parents have not had a personal experience with college.”

Thomas Nary, MD, Boston College

“Tom is right about the finances of parents. Many financial planners advise parents to save for retirement and, if necessary, borrow for college. The implications for both students and parents of this increased debt burden will be significant, not the least of which will be an increased pressure to ‘perform,’ to get value for these costs.”

Ralph Manchester, MD, University of Rochester

“On Tom's point about the growth in first generation college students, my sense is that those parents are less demanding and more deferential to campus authority. Personally, my most rewarding patients are those who are first generation college students. They seem both more mature and more grateful for the opportunity to be in college.”

Greg Moore, MD, MPH, University of Kentucky

“Parents will also continue to be in the ‘sandwich generation’ – responsible for the care of their aging parents while still responsible for their college-age children. And the costs for both are increasing, adding to family anxiety and tension.”

Polly Wheat, MD, Columbia Medical

“Parents have good reason to be confused about the transition to college — a month before college began they were in the exam room with their child, now they are not only not there, they may not be told anything. I talk openly to parents about this transition. I talk about the myths and reality of college health; for example, we routinely ask their daughters if they might be pregnant before we will prescribe certain drugs. I explain that the treatment of choice is often not prescribing antibiotics. I try to suggest that concerns they have which they may formulate as a complaint, be recast into a question. And you know, it works. Parents want as much help in living their new role as they can get.”

Lesley Sacher, MA, Florida State University

“I taught a leadership program for students and routinely would ask each group who their heroes were. The vast majority would cite their parents as their heroes. So it's not surprising that we see manifestations of this relationship when students arrive on campus.”

Todd Holcomb, Iowa State University

“Many of our schools go out of their way to make their children's college experience also a parent experience. We have parent's sweatshirts and parent's weekends. So is it no accident we have delayed onset of adulthood? Thirty years ago, the four year college was the model for the transition to adulthood. For many students that transition does not get completed in college.”

Sarah Mart, MS, MPH, University of San Francisco

“In my experience, parents are not hostile and are often relieved to have the University assume some responsibility. In effect they are saying, ‘I've worked at this for eighteen years, now you take over.’”

Sacared Bodison, MD, MBA, University of Maryland

“I often wonder how much of this is generational. I wonder if we asked these questions of Student Health Service directors of thirty years ago, whether they would have had similar comments about their observed changes in students and parents.”

Bill Purdy, MD, Duke University

(Editor's Note: Dr. Purdy's comments on the generational

issues highlights a major theme of student affairs officers. Their association, NASPA, has developed several publications on this subject.)

"Maybe, but I do think there are also real differences. The objective reality is that costs are higher, competition is greater, career choices are more complex...all reflected perhaps in the very different demand we are seeing today for behavioral health services."

Nell Davidson, MD, Case University

"Another difference from thirty years ago are the communication links between parents and students. Cell phones are assumed to be on all the time. Instant messaging is the norm. When any of this is interrupted, as it was on our campus during Hurricane Isabel two years ago, the parents' expectation was that the University would somehow bridge this communication gap: they seemed to expect individual telephone calls as we were evacuating the campus."

Gail Moses, MD, College of William and Mary

"Gail is probably correct about parents' expectations for communications, but my theory is that a phone call from me to a parent is far better than a phone call from a parent to me."

Michael Huey, MD, Emory University

"I think Bill is correct about the generational aspects of some parental behaviors. First-time, first-year parents are much more anxious, as they were one, two, or three generations ago. The whole process of parent-child separation has been going on a long, long time. We'll continue to see the same dynamics in 2010, 2015, and 2020."

Estelle Maartmann-Moe, APRN, University of Vermont

"In reference to Nell's comments about the 'new complexities', I'd add health insurance. Parents often don't understand what coverage they have, resulting in more high-risk students waiving off health insurance without adequate coverage."

Janet Corson-Rikert, MD, Cornell University

"Because our student health insurance is mandatory, it is designed to work very well with our Student Health Service and with our providers in the community. Our plan is quite easy to understand. In most cases the mental health coverage

we offer is superior to many parents' employer-sponsored plans."

Alan I. Glass, MD, Washington University in St. Louis

"Many of our families have a very good balance between being supportive of their children and letting go. Universities also must strike a balance between being supportive and fostering independence. Our commitments to provide medical, counseling and support systems and also to make accommodations may be seen as fostering dependency. We do know this, and there is certainly a lot of dependency among students. Our challenge is how well do we help parents, students, and ourselves have appropriate expectations in this changing environment as students bounce back from various problems?"

Alejandro M. Martinez, PhD, Stanford University

The consensus of the group regarding the parents of 2010 is that they will incur higher debt as higher education becomes more costly. Parents will both retain some level of protectiveness and cede some of it to the institution. The transition from adolescence to adulthood, as experienced by parents, will continue with 'splitting', where children create good parent and bad parent role assignments, and test limits. Parents and students both will experience increased competitiveness, more choices, increased stress, and increased complexity associated with many aspects of higher education, health care and extended family life."

Changes in Higher Education Over Next Five Years

Six broad themes emerged:

- **Growth:** Although a few large Midwestern public schools anticipate a decline in enrollment, most expect growth and even significant growth over the next five years. (This maybe the last phase of growth before the demographic downturn in high school graduates which will occur about 2009 or 2010.)
- **More international students:** After a post 9/11 decline in international student enrollment, most see this trend reversing, although there will be some shifts in countries of origin.
- **Distance learning:** Technology will push access to classroom content onto the computer. Students can participate electronically from some distance, coming together only occasionally to meet with instructors and

“By 2010, more of us will have to have a combination of social workers, counselors to help students sort out the complexities of the health system.”

other classmates. Others may participate from a largely residential campus, where it is more convenient to use electronic access than to attend class.

- **High-Tech/High-Touch:** Borrowing the phrase from John Naisbitt’s book, *Mega Trends*, of the early 1980s, participants spoke of increasing efforts in higher education to create a highly personal, involved campus community, in the face of more and more ‘e’ communications.
- **Financing** Public support for state schools will decline and be replaced by increased tuition and fees, alumni and parent contributions, and private philanthropy. Federal aid to higher education will also be more limited, including student loans, Pell grants, and other grants and contracts for research.
- **Diversity:** Older students, less-affluent students (adding demand for financial aid), and racial and ethnic diversity will characterize the University of 2010.

Some specific comments:

“We now have 40,000 students. Only 16% of those live on campus. The proximate off-campus housing is referred to by some as the ‘student slums’. From a health perspective, we know this off-campus housing and the students’ lower housekeeping standards have contributed to asthma, allergy, and a variety of upper respiratory infections. We also know as we build out our campus to meet our growth needs, we are taking more and more green space. There are fewer and fewer spaces on campus where you can sit and have some peace and quiet. This has to contribute to the increased anxiety we see in students. My point is there are very real human costs to growth which we have to carefully consider.”

Lesley Sacher, MA, Florida State University

“Higher education in 2010 will be concerned with costs, revenues and deficits. It will also be concerned with the University’s exposure to liability and negligence claims through various courts’ interpretations of the universities’ ‘duty of care’ and the concept of ‘negligent referral,’ particularly with regard to suicidal students. We are all paying close attention to the Shin case. The demographic downturn in high school graduates is also a concern, and is already being felt in the Midwest with declining enrollment.”

Todd Holcomb, Iowa State University

“I would add to that list, a concern about keeping our best faculty. Our faculty is being raided by both other universities and the private sector. Over the next five years, universities will be forced to move money from services and capital budgets to increase faculty salaries. The squeeze on student health programs will no doubt increase.”

Hugh Jessop, Indiana University

“Universities will seek new revenue sources. A primary mission of our University is to become a research institution. One part of this effort is to more fully integrate our teaching with research. But another goal is to bring in new revenue through sponsored research.”

Sacared Bodison, MD, MBA, University of Maryland

“Universities will continue to feel a significant budget squeeze. Not only are costs rising, but we’re now getting pressured to guarantee flat rates for tuition and fees for the four years of undergraduate education.”

Ann Nadler, University of Missouri

“I am not sure we know what distance learning is going to mean for the university. In some models, the course leader is neither a full-time faculty member, nor works from the campus. When the class meets in person two or three times, it may not be on campus, but at some airport or resort convenient to participants. That type of distance learning is totally invisible to those faculty and students who live on campus, but it can be a revenue source.”

Suman Kashyap, MD, Michigan State University

“I am convinced that most of our larger universities will become more and more international. What concerns me is will we become more attuned to what the international students need in terms of health? This concern is in part about our cultural competency, but also about our ability to provide the resources to help these students navigate our truly ‘foreign’ health system and health insurance world.”

Alan I. Glass, MD, Washington University in St. Louis

Student Health 2010: Responding to Students, Parents, Health Care, Public Health and the Evolving World of Higher Education

Synthesizing the discussions of the changing environment for college health, participants focused on seven themes:

- Growth and demand management
- Facilities, including technology
- Staffing: New roles and responsibilities
- Public health
- Behavioral health, counseling and psychological services
- Prescription drugs
- Visibility, value, and resources

Growth and Demand Management

“The University of Cincinnati projects it will grow its student population by 50% in the next five years. I define student health in terms of retention: anything that keeps a student in school and academically productive. This growth will put very significant demands on Student Health for resources. Today, I don't know where these resources will come from.”

John Andrews, MD, MPH, University of Cincinnati

“By 2010, more of us will have to have a combination of social workers, disease management workers and financial counselors to help students sort out the complexities of the health system: referrals, financial issues around high cost care, and managing chronic disease and disabilities (which we will see more of in five years).”

J. Robert Wirag, HSD, University of North Carolina

“We have already done this. I moved someone into this role a year ago and they are overwhelmed with demand. We could easily use two or three more people in this role. This person has totally streamlined our referral process and has freed up a great deal of clinician time. It has been a great resource for students, the physicians to whom we refer are delighted because she knows their procedures, and our clinicians are grateful that they don't have to be as involved.”

Jan Palmer, MD, West Virginia University

“Certainly demand is up and is likely to continue to grow both from more students and more demand for health care services. The question is, how do we decide what parts of this demand are not our business, are not within our skill sets and our resources. We can't be responsible for every student need.”

Greg Moore, MD, MPH, University of Kentucky

“The other side of that question is the students who aren't using our service. Should we be doing case-finding? Our

data suggest that out-of-pocket costs for student health care are a barrier to access which is more significant for students with fewer financial resources. What is happening to those students whom we never see?”

Janet Corson-Rikert, MD, Cornell University

“To meet increasing demands, Student Health will be asked to provide expanded and more comprehensive services in 2010, becoming more campus- or university-focused. These services will be offered to faculty and staff, and may even include expansion to the surrounding community. Programs may include workers compensation evaluations and treatment, marital and other specialty physicals, and travel medicine. These services also will generate revenue, which is becoming more important to all of our bottom lines.”

Kathleen Golden-McAndrew, MSN, APRN, BC, ANP,
University of Massachusetts/Boston

“We have approached the challenge of how to meet the increasing demand for behavioral health by a co-venture with our academic programs in psychiatry and psychology and with campus life. We are adding a half time attending psychiatrist who will supervise two fourth-year psychiatric residents. Similarly, we are providing the clinical setting for two post-doc clinical psychologists. By becoming a training site for college mental health, we have substantially increased our clinical capacity without a huge increase to our payroll.”

Michael Huey, MD, Emory University

Another demand issue for the future is e-mail. Many participants described the need to allocate a block of clinical time each day to answer e-mail.

Facilities for College Health 2010 (Including Technology)

The consensus among participants favored centralized clinical facilities, including behavioral health, with distributed facilities for outreach, health education and programs like yoga, stress reduction, and various group meetings.

“Whether we are in a new facility or a very old one, it has to both look like high-quality care and functionally support high-quality care. It has to be technologically up-to-date, efficient, and respect the privacy of patients. Being designed for the convenience of the staff is not a bad thing, as long as the

convenience of the student is also a priority. Facilities, systems, and patient work flows are central to the accreditation process.”

J. Robert Wirag, HSD, University of North Carolina

“Student Health in 2010 will have to have a fully integrated eHealth technology. In most communities, the hospitals and major group practices will have at least three or four different vendors. There will be dozens of interfaces required. The integration planning will be a huge challenge and involve a major commitment of time and talent.”

Hugh Jessop, Indiana University

“We are committed to have an Electronic Health Record (EHR) by 2010. On our campus alone, this will mean at least 20 interfaces. We hope to standardize HL7 as our link. One advantage of this kind of system is we can more easily use Relative Value Units (RVUs) as measures of productivity.”

James Nelson, Iowa State University

“Improvement in our facility is central to our strategic planning since accreditation will depend on that improvement. I suspect we are not too different from most academic settings with both space and capital budgets being very tight. So we work toward the ‘inadequate, but improved’ opportunity, in which the only services which will fit in our new location are primary care. So we will find satellite space for mental health. Since we have great interest in yoga programs and stress reduction techniques, we are on the lookout for space for those. The good news is that all of our sites, including our hospital system, are fully-integrated electronically.”

Polly Wheat, MD, Columbia Medical

“Regarding the centralized vs. distributed model of facilities, I’ll take the centralized model in a heartbeat. As we discussed at the outset regarding trends in health care, more and more physicians’ groups are consolidating and moving closer to hospitals. So the centralized model is working in the larger community and it can also work for us.”

John Andrews, MD, MPH, University of Cincinnati

Staffing, Recruiting and Training for Student Health 2010

“Recruiting for physicians, nurse practitioners and nurses is very difficult because the administration of the University is unfamiliar with the health care market place for salaries. I am constantly struggling to explain that, although we live in

a higher education environment, our clinicians’ compensation is determined by the health care market.”

Wagida (Gigi) Abdalla, MD, George Mason University

“I am having exactly the opposite experience, perhaps because we are a state institution which has physician employees in a number of state agencies other than the university system. I get calls from physicians all the time who are attracted to the hours, the limited on-call schedules and their perception of what college health is. My challenge is to screen that pool for those clinicians who will really fit into college health.”

Jane Halpern, MD, Towson University

“I am having both experiences – I am getting calls of inquiry, but salaries are still a significant problem.”

Isabel Goldenberg, MD, George Washington University

In the discussion of recruiting, compensation and lifestyle considerations, four themes emerged. There seemed to be significant regional variability regarding both compensation and the availability of appropriate physicians and mid-levels. Second, all agreed that the aging of the college health professional community could become problematic; the consensus was that recruiting should focus on younger staff. Third, that gender balance was important and that men’s health was an area of great need in college health. And finally, great care was required to screen for skill and commitment to college health and not simply the applicants’ attraction to the perceived lifestyle.

Some specific comments:

“I am concerned that we carefully differentiate those who are truly and appropriately attracted to college health and those who are looking for a lifestyle they think may be available in college health.”

Alan I. Glass, MD, Washington University in St. Louis

“We have recently added to our selection criteria the applicant’s comfort with electronic communications with patients.”

Lesley Sacher, MA, Florida State University

“The lines between professional roles will need to be blurred if we are going to have the flexibility we need to meet the future demands. We know some of the professional ‘turfs’ are artificial and were created to protect certain jobs. I am also concerned about the work ethic and professional commitment

what the core competencies are for a successful clinician.”

— EVELYN WEINER, MD, UNIVERSITY OF PENNSYLVANIA

of our new health professionals. The mandate accepted by my generation to devote the time it takes ‘to get the job done’ does not seem to be endorsed as fully by this generation.”

Susan Even, MD, University of Missouri

“We put great effort into staff selection, but we then put our candidates through a very intensive, three day, orientation program. That process exposes them in depth to all of our policies and procedures, who we are and how we work. At the end of these three days we have a pretty good sense about whether our new colleagues will work out. Having said that, as a field, I’m not sure college health has done an adequate job of defining what the core competencies are for a successful clinician. It would be a great topic for a future Spectrum.”

Evelyn Weiner, MD, University of Pennsylvania

“Immediately out of my residency, I saw both general medicine patients and student health patients. That experience reinforced what I had sensed during a college health rotation in residency: taking part in the health care of students is challenging, rewarding, complex and can be a very appropriate career choice for a physician. It is the responsibility of those of us currently in the profession to educate other medical professionals, higher education professionals, parents and students about the field of college health. We should also consider a fellowship training program to help ensure availability of high-quality staff for the future in college health.”

Julia Bonner, MD, University of Wisconsin/Milwaukee

“When you talk about the core competency of clinicians, I think about the ten alternative medicine practices in my small town. There appears to be a significant growth in demand for alternative medicine among college students.”

William A. Christmas, MD, FACP

“We are already there, it is happening now. It is incumbent on us to demonstrate what are the appropriate treatment modalities, including alternative medicine.”

Alastair Smith, MD, San Francisco State University

“People are paying enormous amounts out of their pockets for complementary medicine, which should tell us a great deal about how they value it. This raises the question of whether it should be a covered benefit under insurance.”

Peggy Ingram-Veeser, EdD, APRN, BC,
The University of Tennessee, Memphis

“Regarding recruiting younger staff, we have done that quite successfully. We’re now rethinking what are appropriate expectations for their tenure with us. Some will stay with us a few years and then move on. Is student health a career or simply part of a career?”

Jim Yankech, University of Nebraska, Lincoln

“I’d rather have a good young person for a few years than someone who has been with us a long time and is at the end of their career. This is in part because we are caring for young people, but also because new young people on our staff bring new ideas, energize the organization and help in the process of change.”

Thomas Nary, MD, Boston College

“Diversity and gender issues are large. We really need African American male providers. Our constituency is not limited to students, as we provide some services to the entire campus community. I am not suggesting our staff has to mirror our constituency perfectly, but we have to acknowledge where we have major disconnects.”

Lesley Sacher, MA, Florida State University

“I agree, but you don’t have to put all of the burden for balance on your clinical staff. We provide health services to our food service workers, who do not work sufficient hours to be eligible for health insurance. They are 94% minorities, from 22 countries, and over 80% are Latino. I rely heavily on student volunteers as outreach health works. They must be bilingual. Our model is unique in that we go to the worksite for health screening and some first line primary care. It is our students who help provide appropriate diversity. What has evolved over the years is an incredible service and learning opportunity for our students. We are now partnering with our academic colleagues to introduce some of this content into the curriculum.”

Sacred Bodison, MD, MBA, University of Maryland

Public Health and College Health 2010

The public health role of college health in 2010 will have two themes: First, to be fully prepared to respond to a pandemic, natural disaster, bioterrorism, or local outbreak of infectious disease. Second, to be at the forefront of primary and secondary prevention for students’ major risk factors, principle among them, alcohol abuse.

Regarding the former, comments from participants

“Not only do we not have the time or people to review every student’s someone’s treatment. There could be significant liability in doing so.”

on the preparation for pandemics, natural disasters and infectious disease outbreaks was noted earlier.

The following are the participants’ comments about alcohol.

“We must keep in mind that very little has had any demonstrated value in primary prevention for alcohol abuse. Where there may be potential, is in early childhood and not within the college years or the university environment. So we must focus on secondary prevention, helping those students who get in trouble to avoid it in the future. One technique is the use of motivational interviews.”

Ralph Manchester, MD, University of Rochester

“We have been using the BASICS program, focusing on harm reduction and using a ‘medical amnesty program’ as an incentive for students to participate.”

Janet Corson-Rikert, MD, Cornell University

“Unfortunately, it appears that alcohol abuse among college students increases as test scores or GPAs improve. Is this a function of increased intelligence, increased competition or increased stress, we don’t know, but it means, as many of our schools become more competitive, we are selecting a higher risk population of students.”

Isabel Goldenberg, MD, George Washington University

“I have to believe that the campus culture around alcohol use and abuse is a significant contributing factor. I am equally convinced that the campus culture takes some direction from the University’s leaders. You must have a strong, uniform, and consistent message from the top leaders regarding alcohol.”

Bill Purdy, MD, Duke University

“I agree. At FSU we use the ‘My Student Body’ alcohol screening tool, which we find useful. Social norming is also one of our main strategies. We now need to find simple and effective ways to communicate with our local police, local hospitals and other aspects of our surrounding community about our policies.”

Lesley Sacher, MA, Florida State University

“Whatever our strategies, we should all try to subject what we do to careful evaluation and contribute those evaluations

to the college health literature. The RWJ Foundation has been supporting multi-school research efforts. [Editors Note: The Robert Wood Johnson Foundation is funding the campus/community partnership initiative. The research is already showing that colleges that have developed a strong campus-community partnership strategy to reduce alcohol-related problems are, in fact, significantly reducing heavy drinking and its associated problems.]

Estelle Maartmann-Moe, APRN, University of Vermont

Behavioral Health, Counseling and Psychological Services in Student Health 2010

The consensus among participants was that the demand for psychiatric and psychological services would continue to grow over the next five years and that the financial, human, and physical resources of Student Health would be inadequate to meet this increased demand. The strategies for managing the anticipated gaps between demand and resources were varied, but had three common denominators: flexibility; leveraging other campus resources and community resources; and integration.

“First, I’ll tell you our health fee won’t cover the costs associated with providing for the mental health needs of our students. Our strategy is to have flexible modules – treatment programs involving psychiatry, groups, programs for stress and seasonal affective disorders, programs teaching visualization techniques. Our objective is to reduce barriers to access and find the most appropriate resource for each student.”

Lesley Sacher, MA, Florida State University

“At Cornell, we are fortunate to have behavioral and medical services integrated within the Health Services, so we can collaborate in providing care to students with a range of issues presenting both psychologically and somatically. We are concerned, though, that we are not reaching all students who need care if we wait for them to walk through our doors. We have started to provide counseling services in settings that may be less intimidating for some, including in community centers and academic departments.”

Janet Corson-Rikert, MD, Cornell University

“A separate CAPS program can also work; integration is not the only model. The important thing is that the student gets the necessary and appropriate care without difficulty or

confusion, and that care be coordinated with other care as appropriate.”

Evelyn Weiner, MD, University of Pennsylvania

“The ‘separate, but coordinated’ model can be challenging. With so many students arriving on campus taking SSRIs, often with no accompanying psychotherapy, you probably want some psychiatry in Student Health, even if you have separate CAPS. To have psychiatry totally outside of Student Health can create problems around access, referrals and continuity of care.”

Jane Halpern, MD, Towson University

“My view is that care should be organized around the students’ needs. A student may know that things are not going well, but have no clear sense of why and absolutely no sense of a diagnosis. I think we have the duty to carefully assess all students wherever that student presents for care and to make appropriate referrals.”

Ralph Manchester, MD, University of Rochester

“We all have to decide which students to refer to care in the community and whether and how we’ll try to coordinate that care. My understanding is that MIT’s policy now is only to refer out their ‘healthier’ patients, reserving for care within the SHS those students who may have the most need. One could argue about that policy, but at least they have a policy and have thought it through with some care. I wonder how many of us have a clear referral policy.”

Polly Wheat, MD Columbia Medical

Prescription Drug Use in College Health

The consensus of the group was that the number of students who arrive on campus taking prescription drugs will continue to rise over the next five years raising four challenges.

The first challenge is, what responsibility does Student Health have to determine whether the prescribed treatment continues to be appropriate?

“Most students who come to Duke taking a prescription have never asked their physician how long they should continue, or what the process might be for going off the prescription.”

Bill Purdy, MD, Duke University

“Not only do we not have the time or people to review every student’s prescription, I would be very cautious about changing someone’s treatment. There could be significant liability in doing so.”

Isabel Goldenberg, MD, George Washington University

A second concern is the distribution of prescription drugs from the original patient to others. On November 16, *The New York Times* ran a front page story on this practice called, ‘Young, Assured and Playing Pharmacist to Friends.’

A third concern is the prescribing practice of college health clinicians.

“We are only beginning our process of formal drug utilization review, but we started by looking at antibiotic prescribing patterns. We expected, and saw, significant variability. Our goal was not to identify outliers, but to get providers talking about best practice and appropriate use of pharmaceuticals.”

Janet Corson-Rikert, MD, Cornell University

“We have an active quality management and clinical practice committee which has focused on our overall prescribing practices. Using an interdisciplinary committee, we have reviewed each step in our medication system, from stock ordering, to dispensing. The results: We were able to reduce internal costs; to review best practices in prescribing; to collaborate with local pharmacy representatives to sponsor on-site training and education for our new health care providers, and to supply us with coupons and samples for our patients. We were also able to change some of the high utilization classifications.”

Kathleen Golden McAndrew, MSN, APRN, BC, ANP
University of Massachusetts/Boston

The fourth concern involved liability, errors, and patient compliance. The prescribing discussion was just a part of this. Recent court decisions, particularly the recent Massachusetts court decision in the matter of Shin vs. MIT clearly have had an impact on student health leaders. On the Shin case the court said, in part, ‘By not formulating and enacting an immediate plan to respond to Elizabeth’s escalating threats to commit suicide, the plaintiffs have put forth sufficient evidence of a genuine issue of material fact as to whether the MIT medical professionals were grossly negligent in their treatment of Elizabeth.’ [We note

“It was no accident, I think, that at this year’s President’s Leadership Retreat at FSU the issue was ‘College Health 2010’. The process will transform us to become advocates for the health needs of our campus.” — LESLEY SACHER, MA, FLORIDA STATE UNIVERSITY

this is not a finding of gross negligence, but of sufficient evidence to move the issue forward to trial.]

Visibility, Value and Resources

“The core value of Student Health is to assist the University in retaining students so that students can successfully complete their academic program.”

John Andrews, MD, MPH, University of Cincinnati

“My value message is we help students to ‘engage’, to attend class and participate more fully in the campus community.”

Glen Egelman, MD, Bowling Green State University

“Student Health is on a journey similar to medical records. Prior to HIPPA it was in the basement, now it’s in the Board room.”

J. Robert Wirag, HSD, University of North Carolina

“The value proposition is not simply with student retention and performance. It is with parents. Parents are coming to orientation in very large numbers and are asking good questions and are thoroughly engaged. Parents certainly can help to deliver the value message to the University.”

James Guest, MD, FAAP, University of Nebraska, Lincoln

“A significant part of our value proposition is our participation as part of an integrated, student-focused team. For example, we’ve signed on to share a case manager among residential life, judicial affairs, the Vice President for Student Affairs and Student Health. This person is housed in the Dean of Student’s office. This is not a ‘snowplow’ function, but a ‘seamstress’ task, strengthening the University’s collaboration.”

Lesley Sacher, MA, Florida State University

“I would echo the ‘integration adds value’ theory. Our work on occupational medicine and campus emergency planning has brought us into regular contact with colleagues in environmental health and safety, human resources, risk management and research compliance. As a consequence, many more people are aware of our value to the entire campus community.”

Janet Corson-Rikert, MD, Cornell University

“Having people physically integrated is very helpful in building interdisciplinary teams. We have had an interdisciplinary team working toward that goal for ten years as we planned, built and recently opened our new facility.”

Alan I. Glass, MD, Washington University in St. Louis

“Student Health, now and going forward, will have to resolve several contradictory demands. The pressures for integrated, continuous care will be balanced by demand for episodic, anonymous care. Pressures to achieve efficiency in health care delivery will be challenged by the complexity of disease and anxiety with which students present. Students will want both all the latest in traditional western medicine, while having full access to complementary medicine and pay less for it all. There will be much more data and increased requirements for privacy. Many patients will want active care now, when the clinician knows that ‘Tincture of Time’ is the treatment of choice. How effective we are in acknowledging the legitimacy of these contradictory pressures will determine how we are seen in the larger University community.”

Ronald Elson, MD, University of California, Berkeley

Student Health for 2010 will evolve to serve more students, many with increased morbidity, many with more anxiety and depression, employing a multidisciplinary, flexible and diverse staff. New facilities will be sought, but constrained resources will require many to work out modest, incremental improvements. Technology will change Student Health practices significantly as eHealth becomes a treatment modality commonly accepted.

The threat of a pandemic and other public health emergencies will force planning and collaboration. As Bob Wirag commented, Student Health “will move from the basement to the Board room.”

Most importantly, the Leadership Forum participants saw many opportunities and virtually no threats. This is a journey from good to better.

Five years ago this conversation would have included great concern about outsourcing. In response, we have created a much greater understanding and visibility about what we do.



The Future of the Health Care System in the United States

Drew E. Altman, PhD, Henry J. Kaiser Family Foundation

Editor's Note: One of the key determinants of the future of college health programs will be how the health care system in the U.S. will evolve. There are few experts in health policy who can match Dr. Drew Altman's experience, expertise, knowledge and insight on this subject. As president of the Kaiser Family Foundation, Dr. Altman has had the ability to form his opinions with rigorous, time series survey research in public opinion and health policy. *Spectrum* spoke at length with Dr. Altman in early January.

Spectrum: Dr. Altman, as you look out over the next three to five years, what do you anticipate in terms of underlying health cost trend?

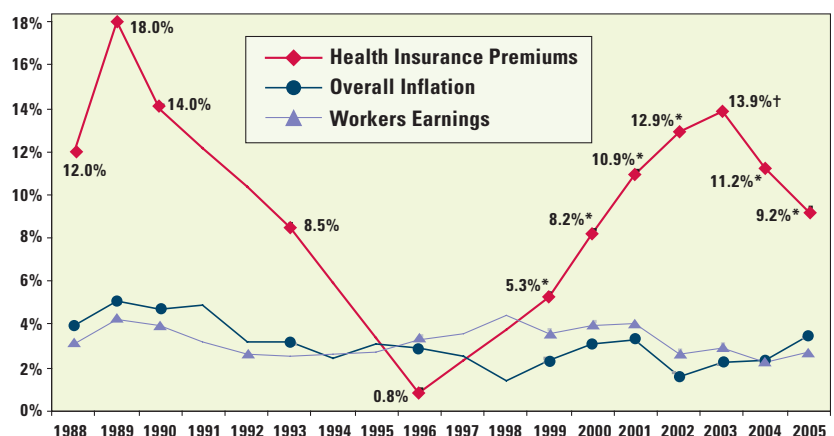
Dr. Altman: We are in a period of slight moderation in terms of increases in health costs, but there is very little to celebrate. We are still seeing health care costs increase at rates of about four times the rate of wage increases for the average worker, so the pain level is still very high. We have seen these slight dips before, and the one thing we can say with confidence is that health care costs always bounce back and they usually bounce back with a vengeance. So, I can't be sure, but my expectation is that we will see health cost inflation bounce back to at least the low double digits within the next two or three years (see *Figure 1*).

I don't think we have any meaningful answers to this problem. If you think about recent history, the American people rejected strict managed care. And regulation is so strongly opposed by health care's big commercial interests that it is not remotely in the cards politically. So we are left with nothing except a handful of modest halfway measures. So we should expect to see health care inflation greatly exceed inflation and the growth in people's wages for the foreseeable future.

Spectrum: Since you anticipate underlying health costs will rise at rates significantly greater than GDP (Gross Domestic Product) growth or household incomes, will the recent patterns of cost-shifting to the consumer through increased deductibles, co-payments, plan limits, eligibility and premium sharing continue?

Dr. Altman: Employers are out of answers, so their response has been to absorb what increases in health costs they can, and to shift the rest of the increase to their workers. It is not something they want to do but they felt they had no other option. We should expect that this cost shifting to employees will continue, but probably not increase substantially because there are limits to how much they can do this. While employers are now feeling that they are out of options, at the same time, they've never wanted to push for a much stronger government role. So, they have never become the strong advocates for national solutions many had hoped they would.

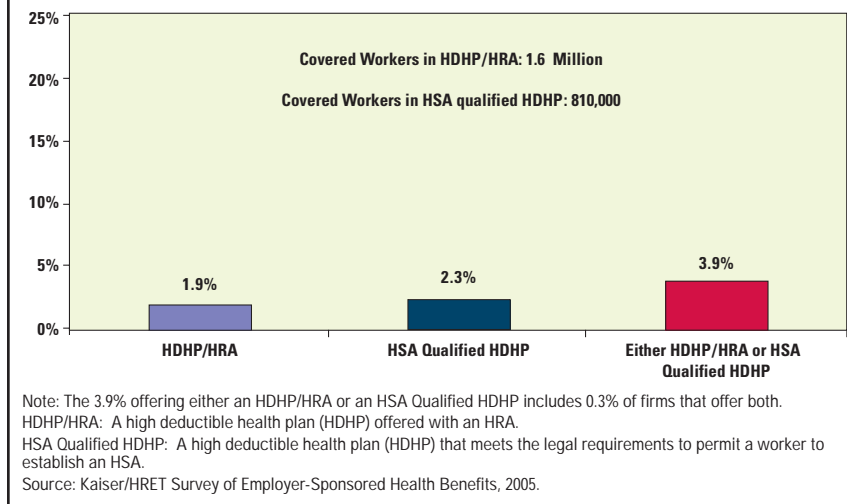
Figure 1: Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



* Estimate is statistically different from the previous year shown at p<0.05. No statistical tests were conducted for years prior to 1999.
† Estimate is statistically different from the previous year shown at p<0.1. No statistical tests were conducted for years prior to 1999.
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.
Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA), 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1988-2005; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2005.

“The bottom line is that health insurance is becoming increasingly unaffordable, and we should expect to see the ranks of the uninsured, already almost forty-six

Figure 2: Among Firms Offering Health Benefits, Percentage Offering an HDHP/HRA or HSA Qualified HDHP, 2005



Spectrum: That cost-shifting could lead to at least three changes: more people deferring care; increases in uncompensated care; or the development of less-costly treatment alternatives. With regard to the latter, we'd include nurse practitioners staffing walk-in clinics, increased telephone access through nurse lines, and Web-facilitated, self-care. Regarding deferred care, some will be appropriate, but some will not and may lead to deteriorating health status. Please talk with us about how you think consumers will make choices in light of increased out-of-pocket payments, and how the delivery system might adjust to these changes in consumer behavior.

Dr. Altman: The bottom line is that health insurance is becoming increasingly unaffordable, and we should expect to see the ranks of the uninsured, already almost forty-six million, go up. This will be driven largely by small employers who will be forced to drop coverage. We should also expect to see all sorts of lower-cost health insurance arrangements, which, on the one hand, are more affordable, but on the other hand, provide much more limited benefits. So, I think we are going to have a new debate in the country about what adequate health insurance is. When is health insurance not meaningful?

As part of this debate we may begin to see interest in direct health care delivery options as an alternative to health insurance. The problem is, direct delivery is not

a substitute for health insurance, because it inherently limits and rations care. So, we will see many arrangements — from direct delivery to very scaled-down insurance as second choice alternatives in the face of rising health care costs. We are also going to a disproportionate impact of all of these changes on a relatively small number of health care providers, the so called safety-net providers. While many focus on the differences between the non-profit and for-profit providers, the most important outcome of this rise in the uninsured will be on those hospitals, clinics, physicians and other safety-net providers who provide the lion's share of the care for the

uninsured. Many of these are public institutions, some are urban academic medical centers, some are religious institutions, but they all will feel the disproportionate impact of the erosion of health insurance which is occurring across the country.

Spectrum: Your comment regarding the disproportionate impact on the safety-net providers suggests there will be a disproportionate impact as well on their historic patient population, the poor and the working poor.

Dr. Altman: Absolutely. The working poor always take it on the chin in our country and it's not just with regard to health, it's across the board. It is not supposed to be that way. Our ethos is, if you go to work every day and you work hard, you are supposed to be OK, but unfortunately, our systems are not set up that way. The working poor fall in the gaps for health care, for income security and for other areas as well.

Spectrum: As we talk about consumerism, we cannot ignore the growth in high deductible health plans or Consumer-Directed Health Plans, backed up with Health Savings Accounts. Early critics suggested these would be plans for the "healthy wealthy," but as they have grown in popularity, they also seem to be picking up people who were previously uninsured. What is your view

on how these plans will mature over the next five years and their implications for the delivery system?

Dr. Altman: We are definitely seeing growth in what some call Consumer-Directed Health Plans. We are seeing growing interest, particularly among jumbo employers in high-deductible plans. We are also seeing growing employer interest in the more “orthodox” consumer-directed health plans – those which tie high-deductible plans with health accounts, either HSAs or HRAs (health reimbursement accounts). At the same time, today there are only a few million workers enrolled in these plans, so it is still very early and not possible to suggest that such a small group would have any impact on the larger health system yet. That’s not a criticism, it is just the way the numbers work (see *Figure 2*).

Secondly, these plans are not going to have an impact on our system unless those sick people, on whom we spend most of our health care resources, enroll in these plans. The debate is just beginning about whether these plans would be appropriate for really sick people. It may work out in the long run that these consumer-directed plans are a good deal for some employers and some people, but not for everyone, or not a good deal for our health care financing system overall. What is clear is that they will not be good for our health system if they disaggregate the risk pool and drive up costs for those who are the sickest among us. It’s still too early to form any judgment about that, but the disaggregation of the risk pool is the thing we should be most on guard about.

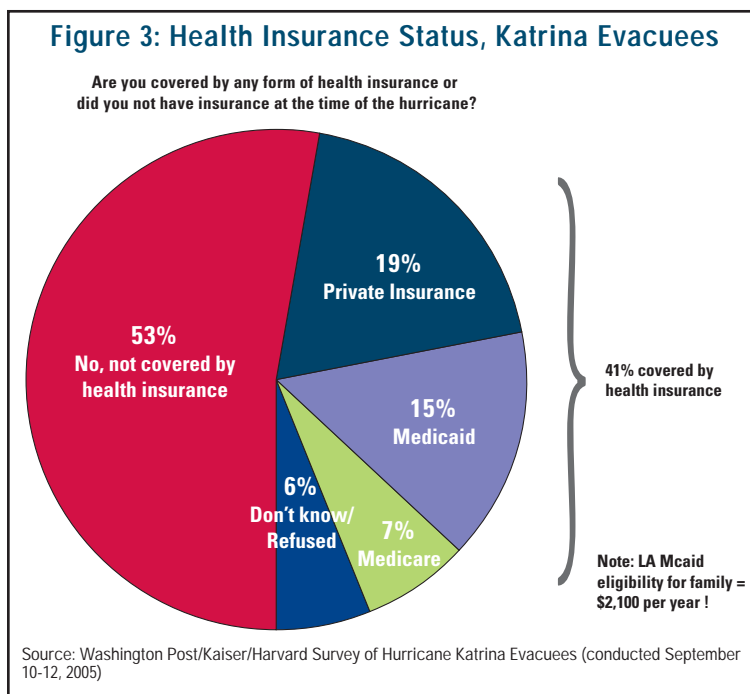
Spectrum: Your Foundation studied the demographics, disease burden, and resources of the population of New Orleans displaced by Hurricane Katrina. What are the lessons from this analysis?

Dr. Altman: We were fortunate to be able to survey many of the Katrina evacuees, mostly in shelters in Houston, in partnership with *The Washington Post* and colleagues from Harvard University. What really struck me most of all was what a powerful symbol of the problems in our health care

system those people on the rooftops were. They were lower income, working Americans, without health insurance, dependent on safety-net institutions, especially charity hospitals. They were the southern version of America’s uninsured. They are exactly the people about whom we debate all the time when we ask: “Who are the 46 million uninsured?” There they were: employed, lower income, uninsured, depending on charity care, sitting on their rooftops waiting to be rescued by those orange and white Coast Guard helicopters; a vivid portrayal of the working poor (see *Figure 3*).

As we think about these new health care arrangements, we must ask, will they work for those who make less than \$20,000 a year per family? What about those who make less than \$10,000? The Katrina refugees for the most part had no savings; the majority, no credit cards; and a significant percentage, no cell phones. We have to think about how those new health care arrangements, based on shopping in the private market, based on the principles of individual responsibility and risk, are going to work out for a significant portion of the population, a population symbolized by those people on the rooftops.

Setting aside the debate in the Congress about cost-sharing for Medicaid, we already see our seniors struggling to make choices among 30, 50, or 60 different drug plans



“...at the heart of all these changes is a much broader question...what do we, as a collective responsibility for one another...or is it an individual responsibility

under the new Medicare drug law. We have to think about whether these arrangements are really practical for a significant portion of our population.

Spectrum: You have commented that the process by which public policy at the federal level is developed is changing. You have suggested that the art of political compromise is being replaced by firm beliefs on both sides of the aisle about social responsibility vs. individual responsibility. How do you think this will play out over the next five years in terms of the uninsured and underinsured?

Dr. Altman: I think we are in a time when it is easy to miss the forest because we are just looking at the trees. You look at any individual tree, all you may see is a modest proposal for consumer-directed arrangements with just a couple of million people enrolled here and there. And you see another tree, a debate on the Hill for some co-pays for Medicaid. You see a prescription drug law where people have many options and choices. So if you look at any particular program or proposal each may seem to suggest a modest change. But, if you step back and look at the forest, you see what may be the beginnings of a profoundly different approach to health insurance, based on the principles of individual responsibility and risk. I suppose that is what the President has in mind when he speaks more broadly of an “Ownership Society.”

I do think at the heart of all these changes is a much broader question, which is, what do we, as a nation, see as our philosophy underlying our health insurance programs? Is it a collective responsibility for one another, including those in greatest need; or is it an individual responsibility to make our own choices with the risk that goes along with that? As part of this, we are seeing, potentially, a redefinition of what we mean by health insurance. What we used to mean was a pooling of risk across a very broad group, where those of us who are healthy subsidize those who are sick — doing so with the certain knowledge that we would all be sick someday. We are redefining that now, with the phrase of the year, “the disaggregation of the risk pool.” Under this approach, people will make whatever arrangement they think best suits their situation, and accept the associated risks, but not accept any risk for others.

So, I do wonder if we *are* missing the forest, which

has very profound implications for how we conceive of health insurance — implications which will be much more serious for those with less education and lower income who will have a much harder time coping with these changes, which are appearing to gain a foothold in America today.

Spectrum: Earlier, you had made several comments about “safety-net health care providers” providing direct care to uninsured populations. In Don Moran’s article in the January/February 2006 issue of *Health Affairs*, he comments (citing the VA experience), “policy makers confronted with the problem of declining private insurance coverage could find filling the gap with direct care resources a cost-effective alternative to attempting to replace lost private insurance coverage with new sources of public insurance coverage.” Your thoughts? Could this signal a new life for community health centers?

Dr. Altman: It would absolutely be good to see a revitalization of community health centers, and to put more resources into them. They have been essential in providing access to good care for low income people. But while they have a huge and important role to play, it would be a grave mistake to think that community health centers — or any other direct delivery system — can be an adequate alternative to health insurance.

One of the first articles I published many years ago was on this very subject, “Direct Delivery as an Alternative to Health Insurance.” The conclusion I reached was that while direct delivery had an important, and even essential role, in providing access to care as a backstop for holes in our health insurance system, it could never be a substitute for insurance. This is because health insurance is more comprehensive and allows people to vote with their feet, to go where they need to go to get the care they need to get. Further, allowing access to care only through public hospitals and clinics for some part of our population inherently rations care for those people. Waiting in a long line in an emergency department is not the same as having an insurance card which permits you to go to whichever provider in the community you choose, or to get good preventive care.

The logic is flawed in another way as well. If you

a nation, see as our philosophy underlying our health insurance programs? Is it to make our own choices with the risk that goes along with that?"

spend any time at all understanding the financing of our safety-net institutions, you know that the lion's share of their revenue comes from our public insurance programs. Take that away, or even erode that revenue source, and they will have no way to survive. We would have to replace the revenue they derive from public insurance with direct grants-in-aid instead. Thus, we would not save any significant amount of money. So direct delivery systems, including community health centers, have a critical role to play, and community health centers, in particular, need more resources right now to fulfill their roles as currently structured, but it would be a huge mistake to consider them as an alternative to health insurance.

Spectrum: One variation on cost-shifting is to transition to a defined contribution program, rather than a defined benefit. Not only are some employers doing this, but some states have Medicaid waivers to test this. It may well just be a mechanism to shift costs to the individual, but we would be interested in your opinion on defined contribution health plans.

Dr. Altman: I think this is a piece of the subtle, underlying change I was talking about a moment ago. You can see, in the Florida Medicaid waiver experiment, which is just beginning in two counties, a small scale example of the fundamental philosophical change which is occurring. But you can see it even more profoundly in the Medicare prescription drug law: we now have the advent of two fundamentally different health insurance systems under Medicare. On the one hand, you have the traditional program with the defined benefit, where everyone gets the same benefit at the same price. And, on the other hand, you have the Medicare Part D program, where people get different benefits based on what choices they make. So we have two health care systems running side by side within Medicare. How this will play out will have profound implications, not just for Medicare, but for our entire health care system. These are changes which are not really getting much attention, but they are potentially extremely important and deserve a lot more national discussion and debate.

Spectrum: You have made the point elsewhere that

the Medicaid waiver program will permit any number of different strategies to be tested without a unifying federal standard. Tracking these various programs will be challenging, even for an organization as large and sophisticated as the Kaiser Family Foundation.

Dr. Altman: About half the states are submitting waiver proposals. While there are some important issues on Medicaid currently before the Congress, the real action and drama is at the state level, where potentially profound changes are going to be made through waivers. It is quite possible that we will wake up some day and find that Medicaid, our largest health insurance program covering 54 million people, has been quietly changed on a state-by-state basis without any national discussion or debate. Certainly that warrants much more attention and a much brighter light shined on it that we have right now. This will be very difficult to do because the waiver process is an arcane and intricate administrative and bureaucratic process which very few people understand.

Spectrum: And will the data be there for those who do understand the waiver process and want to study the impact of these changes?

Dr. Altman: It takes years and years and it is happening not only state-by-state, but often county-by-county, within a state. It is a difficult process for the sophisticated health policy researcher to follow and virtually impossible for the popular press.

Spectrum: So, to summarize what you have told us, it is your view that health care costs will continue to rise for the foreseeable future at rates three to four times greater than the average increase in wages. This gap will be filled in part by employers continuing to shift costs to employees through reduced benefits, greater limits on eligibility and increased premium sharing, and in part by employers absorbing these increases either through decreased profits or increased prices. And some employers will simply not offer health insurance to some or all of their employees.

All of this will result in more people who are uninsured and perhaps even more who are underinsured. How long can this imbalance be tolerated?

Dr. Altman: I think for a long time. We have not shown any great will to solve these problems thus far. The numbers of the uninsured are up, but America has shown no commitment to resolving the burden of the uninsured for a long, long time. I am asked this question all the time, and I answer that it has been a problem for a long time and, historically, there have been times when it was substantially worse (see *Figure 4*).

In the late 1980s, for example, the health cost increase was 18%. It is especially bad when health costs are rising

I look the audience in the eye and I say, “I think what we are going to do is we are going to pay.”

And they look at me as though I were crazy, and they want to throw me out of the room. But, in all honesty, I think that is exactly what we are going to do — pay. This is because we cannot agree on any meaningful answer, so we will fiddle around at the margins with solutions which, at best, will shave a point or two, which is not inconsequential, off the rate of increase. But when that’s done, the rate of increase will still be much higher than the average increase

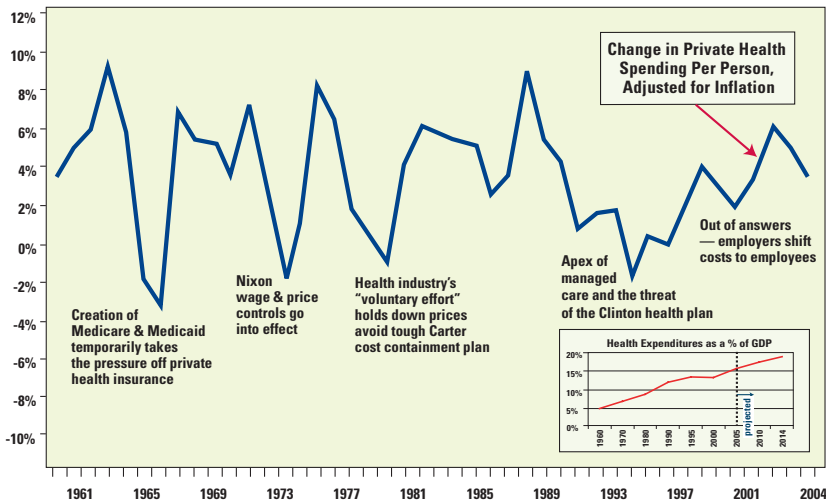
in wages and we will still end up paying that difference. It is useful to remember that people often paint the drug companies, the insurers and even the doctors and hospitals as the villains here, but at the end of the day, the ultimate enemy here is us, the American people. The principal culprit behind rising health costs in our country are the advances in medical technology. Medical technology is the religion in our country. We, as a people, want the latest and the best in health care, and we want it now! And we want it down the street, in our own community.

So I always say, at the end of the day, the enemy is us, and that is why this is such a tough problem to solve. We are unwilling to give up anything in terms of our own health care or access. Instead we want to believe this is

all a problem of waste, fraud, and excessive profits. There may be some truth there, but that truth hides the ultimate driver, our consumption of health care resources. So rather than face that, we end up paying with all the consequences which go with that, and we leave 46 million people out of the system altogether.

Drew Altman is President and CEO of the Henry J. Kaiser Family Foundation, a non-profit, private operating foundation that develops and runs its own research and communications programs. The Foundation is a trusted independent voice and source of research and information on health care in the United States. Dr. Altman joined the Foundation in 1991 and led a complete overhaul of its mission and operating style. Dr. Altman is a former Commissioner of the Department of Human Services for the state of New Jersey under Governor Tom Kean (1986-1989). Prior to joining the Foundation, Dr. Altman was director of the Health and Human Services program at the Pew Charitable Trusts, a vice president of the Robert Wood Johnson Foundation, and served in a senior position in the Health Care Financing Administration in the Carter administration. Dr. Altman received his BA from Brandeis University and Masters in political science from Brown University. He earned his PhD in political science from the Massachusetts Institute of Technology, did his post-doctoral work at the Harvard School of Public Health, and taught graduate courses in public policy at MIT before moving on to public service. Dr. Altman is a member of the Institute of Medicine and the American Academy of Arts and Sciences. He can be reached at drewa@kff.org.

Figure 4: The Sad History of Health Care Cost Containment



Source: Kaiser Family Foundation analysis of data from the Centers for Medicare and Medicaid Services, Bureau of Labor Statistics, and Bureau of Economic Analysis. *Health Affairs*, January 2002.

rapidly and the economy is faltering. Even at those times, we have shown a tremendous capacity to tolerate these problems and look the other way. Truth be told, it is not the issue of the uninsured that is on peoples’ minds when they tell us on surveys they are concerned about health costs. It is, principally, the increases in their own health care costs that concern them. And, even those issues are not on their minds when they pull the lever in the voting booth. Although they are concerned about their pocketbooks, the health cost issue does not come through when they vote because right now voters are more focused on Iraq and terrorism and keeping the country safe. So it is likely we will tolerate rising health costs for a long while.

In the current political environment, I don’t see health reform making its way to the top of the political agenda, as it did in the early 90s, in the ill-fated and failed Clinton health reform effort, in a way that would at least give us a chance to have a meaningful national debate on how to address these issues.

I am often asked at conferences, “So, Dr. Altman, what are we going to do, faced with these rising health costs, and all of the difficult side effects that they have?”

The University, its Students and Their Health: The Past, The Present, and The Future

Bill Purdy, MD, and Larry Moneta, EdD, Duke University

Editor's Note: Central among the factors influencing the future of student health will be "the higher education experience" as it evolves over the next several years. Spectrum asked Drs. Bill Purdy and Larry Moneta from Duke University to contribute their thoughts on what these changes will be and how they might affect student health. As you read this essay you may say, "I know that." And you will be right. But read on, they raise some core questions which we all must try to answer.

L ooks can be deceiving. Visit almost any American residential college campus today and chances are the environment won't look much different from what you might have seen ten, twenty, or even thirty years ago. The red brick academic buildings built in the 1950s look as shabby as ever, while the brutal, concrete facades of the 1960s and 1970s still remind us of the dark ages of urban architecture. On some more fortunate campuses, the ageless beauty of Gothic or Georgian design elegantly bordering expansive lawns and gardens heralds a tradition from centuries past.

But look closer and differences reveal themselves — some subtle, others dramatic. One might notice a peculiar breed of young men and women traversing the campus with small metallic devices pressed to an ear, chatting enthusiastically to whomever cares to listen. Still others lounge on benches, lawns and steps pecking away at wirelessly networked devices ranging from computerized laptops to assorted palm-sized gadgets. Students listen to innumerable MP3 files and, in some cases, lectures, stored in a pod the size of a candy bar.

Other differences are apparent as well. With more cars populating campuses, fewer people walk from place to place. Yet, the recreation center bulges with students pushing themselves to cardio extremes. Food of every type imaginable can usually be found in marketplaces, on-campus restaurants, snack shops and coffee houses. But few students seem to take the time to really enjoy their meals. An army of vending machines complement

the fast food vendors, sushi bars, and grande marche, even as the campus is swarmed by deliveries of pizza, sandwiches, tacos and subs. A glance at your watch might reveal the awkward time of night at which such deliveries swoop in. Early morning hours are now prime time for our hungry, sleep-deprived, highly active young college students.

We could go on and note the substantial differences in "adult presence" on campuses with diminished faculty engagement in the lives of our students. We could point out the research showing heightened levels of stress and anxiety in students along with the expanding numbers of substance abusers, image conformists and ethically challenged students. We could also note with pleasure and pride the remarkable achievements of emerging leaders, who volunteer in large numbers in both local and remote locations.

Perhaps the most dramatic shift can be spotted in the myriad identities of our students. Nationwide, we now see more women than men on our campuses. Racial diversity has expanded, as has an international presence. Expanded Western, Eastern and Mid-Eastern religions are evident with increased demands for prayer and meditation spaces, dietary needs and clergy. Gay, lesbian, bisexual and transgender students are out and about, and multi-racial populations are growing on some campuses even faster than any 'official' under-represented or minority racial or ethnic group.

Things change. Every year is different. Sometimes our plans to meet these changes are right on target; other times we miss the mark. Is adapting more difficult today than ten or twenty years ago? It sure feels like it. Technology advances every day, and the ease with which college students embrace it challenges and bewilders those of us who grew up in a "slower" age.

But are things really that different today? Are our frustrations with today's youth more remarkable than the frustrations of administrators in the 60s and 70s? Wasn't

*“College Health Centers many years ago were minimally staffed, not credentialed
Today we are much more sophisticated, modern and able to provide top quality*

their job just as challenging and uncertain? While they were concerned about student unrest, we worry about Internet overuse and social isolation. They fretted about free love and moral decay, while we have trouble understanding the culture of hooking up and the prevalence of political disinterest. They had to tackle drug and alcohol problems; we still do.

Years ago, when students looked at their classmates, they were likely to see many others just like themselves. Today the population is more diverse racially, ethnically, and financially. Due to advances in medical science, colleges are now able to admit students who, in previous years, would have had to stay home or much closer to home. Mental health issues, long a taboo topic, are now more openly discussed and accepted. Larger numbers of incoming students arrive on campus already on medications — many with no identifiable treatment plan.

In the past, logistics prevented parents from having a campus presence. Communication from students to parents consisted of a rare letter or the once-a-week phone call from the pay phone in the dorm lobby. As part of the college experience, students were expected to handle things on their own. Nowadays parents often play a more involved role. The advent of e-mail and cell phones allows instant, cheap communication from anywhere in the world. It is not uncommon to hear students discussing test questions with their parents as they leave the classroom. The hovering ‘helicopter’ parents (or in the northern states, the ‘snowplow’ parents) can hold their children’s hands as they navigate every obstacle of the college experience, potentially denying students important lessons in independent problem solving. College was once viewed as the period in which parents and children finally break away from each other. This may no longer be true.

What does this all mean to Student Health Centers? An advertising campaign at a major university proclaims, “We aren’t your father’s Student Health.” College Health Centers many years ago were minimally staffed, not credentialed and interested mainly in providing a triage station for routine care. A nurse, probably dressed in starched white with a matching cap, was the primary health care provider. If a doctor was

involved, it was usually for an hour or two, at most several times a week. Today we are much more sophisticated, modern and able to provide top quality care. Physicians are choosing college health at an early age and considering it their profession. Student Health Centers are being credentialed by national organizations — to ensure they meet the accepted standards of care. Health promotion and health education programs reach out to the entire college population, trying to educate, counsel and proactively address students’ needs. But how can we keep up in the age of rapidly advancing technology, rising costs, involved parents, and increasingly more complex students from both a physical and mental health point of view?

What role will insurance play? Every year we deal with increasing premiums, which are especially difficult for graduate students and their families. Most students have little concept of how insurance works and have been sheltered for years by their parents’ policies. Some even consider it a prepaid plan. Many of us find ourselves giving an “Insurance 101” course every year at contract renewal time. Will the role of all Student Health Centers change to include the spouses and children of those enrolled — as many already do? Are there other ways we can incorporate services to lessen the financial impact on students and their families?

Many of us are now using full electronic health records with all the incorporated benefits and drawbacks. We now have reams of data but haven’t figured out how best to use it — let alone pay for how to use it to its full capability. We see that health providers with years of graduate training are now being asked to spend 20-25% of their time typing. We use e-mail to communicate with our students, which they love; and we think we do, too, but are still a little unsure. An “encounter” is being redefined. If we assign triage nurses and providers to answer e-mail, give advice, and even treat, the number of students actually seen in the clinic may be far different from the present. Will we see more patients in clinic because of increased electronic communication with the student body or will we solve many of the routine problems online and therefore save the student an in-person visit? Furthermore, what impact will the increased

and were interested mainly in providing a triage station for routine care... care.”

availability of video phones have on our practice style and numbers? Will we, as Thomas Freidman suggests in his book *The World is Flat*, sign out to a triage service located in India? After all, how important is traditional “face-to-face” medicine? If we can communicate with and see the patient, do we really need to be sitting in the same room? Are we still treating patients if we don’t use “touch”—taught for years as one of the cornerstones of patient care?

Maybe that is the central question: where does touch fit into an ever evolving and advancing technological age? How can we stay connected with our patients when technology is pushing us further and further apart? Are we working more and more with a generation where touch is not as important or at least has to be redefined?

No one knows for sure what the next five years will bring. Expanding technologies will likely continue to make everything quicker and easier. We’ll have to accept that shift. Although things are not as they were a few decades ago, it doesn’t necessarily mean they are worse. More abundant data will require the time and money to properly interpret it. Most important will be the continued effort to make personal contact with each student — maybe in novel ways — to ensure we continue to provide the best care possible.



Bill Purdy, MD, joined Duke Student Health in the spring of 1998. In 2004, he was named Interim Medical Director, and on July 1, 2005, became the first Executive Director of the Duke Student Health Center. He graduated from Case Western University School of Medicine in 1977 and spent the next three years at the University of Wisconsin, Madison completing his internship and residency in Pediatrics. In 1980, Dr. Purdy and his family moved to Kalamazoo, Michigan where he spent the next 13 years in private practice, followed by five years at the Michigan State University Kalamazoo Center for Medical Studies. He can be reached at bill.purdy@duke.edu.



Larry Moneta, EdD is Vice President for Student Affairs at Duke University, where he leads the central planning, policy formation, and coordinating agency for the University concerning student issues. Dr. Moneta worked in student affairs on a variety of campuses before joining the Duke community in August 2001, most recently at the University of Pennsylvania as Associate Vice President for Campus Services from 1997 to 2001 and Associate Vice Provost for University Life from 1992 to 1997. He received his EdD and BS from the University of

Massachusetts and his MEd from Springfield College. In addition to his administrative duties, Dr. Moneta teaches a wide variety of courses, consults for institutions across the country, and presents regularly at conferences and workshops. He is an active member of NASPA, ACPA, and other organizations, serving NASPA most recently as a member of its National Academy for Leadership and Executive Effectiveness Board and as a member of the NASPA Foundation Board (2000). He can be reached at larry.moneta@duke.edu.

A TRIBUTE

The Future of the University: Some Thoughts From the Late Peter Drucker

Peter Drucker, author, management and organizational innovator, died just short of 96th birthday this past Fall. A few days after his death, Steve Forbes, president and CEO of Forbes, Inc. and Editor-in-Chief of *Forbes* magazine, wrote an op-ed tribute to Drucker in *The Wall Street Journal*. He said in part:

“Mr. Drucker...told us to expect enormous changes that will come in higher education, thanks to the rise of satellites and the Internet. ‘Thirty years from now big universities will be relics. Universities won’t survive. It is as large a change as when we first got the printed book.’ He believed ‘High school graduates should work for at least five years before going on to college.’ It will be news to most college presidents and a lot of alumni that ‘higher education is in deep crisis. Colleges won’t survive as residential institutions. Today’s buildings are hopelessly unsuited and totally unneeded.’ All this from a life-long academic.”

* * *

“How higher education is managed did not impress Mr. Drucker; but what did is our continuing education system, whether in community colleges or by computers. Also: ‘Our most important education system is in the employees’ own organization.’ That is where most Americans learn the most. Mr. Drucker also came up with the admonition of pursuing your opportunities and cutting your losses: ‘A critical question for leaders is, when do you stop pouring resources into things that have achieved their purpose?’”



Preparing for Pandemic Influenza: The Role of College Health

Edward P. Ehlinger, MD, MSPH, University of Minnesota

Introduction

Influenza has been a major contributor to the development of college health. The 1918 influenza pandemic led to the creation of many college health services (including the Health Service at the University of Minnesota) and to the expansion of those already in existence. Subsequent pandemics, though less severe and dramatic, have reinforced the need for health services on college campuses. And the yearly reappearance of “regular influenza” on campuses continually reminds us of the tremendous impact that this disease has on the functioning of colleges and universities and the necessity to deal with its consequences.

From the first year of an on-going “Cold and Flu” surveillance study being conducted among University of Minnesota students, it appears that from November to April over 90% of students have at least one upper respiratory infection (URI) which includes both colds and influenza-like illnesses (ILI). Over 80% of students have at least one cold and over 35% have an influenza-like illness. It is estimated that 50-80% of those with an ILI probably had influenza. In a year when 10% of students received a “flu

shot,” this means that up to 22% of students may have had influenza.

The “burden of illness” of URIs and ILIs among University of Minnesota students during a non-pandemic flu year is outlined in *Table 1*.

Given the major impact that “regular flu” has on campuses each year, one can only imagine the devastation that a more virulent and wide-spread strain of influenza will cause.

In trying to determine that impact, the U.S. Department of Health and Human Services (DHHS) has outlined some assumptions that can be used for planning for pandemic influenza. Pertinent to college health are the following assumptions:

- Susceptibility to the pandemic influenza virus will be universal.
 - When the clinical disease attack rate will be approximately 30% in the overall population.
 - Of those who become ill, 50% will seek outpatient medical care.
 - Hospitalization rates and death rates will depend on the virulence of the virus. Some experts believe that young adults could be one of the most severely affected groups.
 - Absenteeism may reach 40% during the peak of the outbreak. Other public health measures like closing schools and quarantining household contacts will likely increase rates of absenteeism.
 - The incubation period for influenza is approximately two days and viral shedding will be greatest during the first two days of illness. On average, infected persons will transmit the infection to two other people.
 - In an infected community, a pandemic outbreak will last about 6-8 weeks.
- If these assumptions are close to being accurate, it is obvious that colleges and universities

Table 1: Burden of Illness of URIs and ILIs (n=3249)

	All URIs (total outcome; Nov.-Apr.)	ILIs (influenza season; Jan.-Apr.)
Incidence of illness	91.0%	27.9%
Days of illness	45,219	9,478
Bed days	6,023	2,043
Days of missed class	4,263	1,406
Days of missed work	3,175	1,000
Health care visit	22.2% (of cohort)	29.3% (of those with ILI)
Antibiotics	15.8% (of cohort)	17.3% (of those with ILI)

“Given the history of influenza, most experts believe that it’s just a matter of time before an influenza pandemic occurs. It may not be this year or the next, but it will occur.”

(along with every other community agency and institution) will be severely affected by a pandemic influenza outbreak.

The most important assumption being made is that a pandemic influenza outbreak will occur. Given the history of influenza, most experts believe that it’s just a matter of time before an influenza pandemic occurs. It may not be this year or the next, but it will occur. The pandemic may be caused by the H5N1 virus, but it may be caused by another influenza variant. That is the nature of influenza – it is unpredictable and it’s inevitable.

With this assumption and the projected devastation that a pandemic will cause, planning for its arrival becomes critical – especially for college health services, which may play a central role in responding to this disease. It appears that influenza is set to shape college health for another hundred years.

Role of Colleges and Universities in Pandemic Influenza Planning

Regardless of size, colleges and universities are an important and integral part of the communities in which they are located, and they contribute significantly to the local culture and economy. Most faculty and staff, and many students, live off campus and are major contributors to civic life. They also possess talents, skills, and expertise that are crucial to the development of the community and are a resource that can be tapped during emergencies or crises. This is particularly true for large campuses and those campuses that house academic medical centers.

Colleges and universities also add to the diversity of a community. The presence of international students and visiting faculty and the increasing number of study-abroad programs for domestic students expands the cultural and intellectual mix of a community. However, this diversity also increases the risk of importation of infectious agents from every part of the globe.

Given that nearly all parts of the globe are accessible within 36 hours, it is likely that an infectious disease, like

influenza, could be unwittingly carried into a community by an arriving student or faculty member. It’s also likely that students and faculty could be caught in the middle of a foreign outbreak and need to find a way to get back to home. In either scenario, it’s unlikely that the disease will be contained in an isolated individual or an isolated location, but will quickly spread throughout the campus and the community. Because of this, colleges and the surrounding communities will be at the front line in our response to pandemic influenza. A well-developed, coordinated plan that includes state and local health departments, community hospitals, local medical personnel, and colleges and universities will be crucial in controlling the disease as much as possible.

As part of that planning effort, colleges and universities need to develop reasoned responses to the unique challenges that they will face. They need to develop plans in, at least, the following areas:

- *International travel:* With students and staff traveling throughout the world, colleges need to develop and implement tracking systems and provide travel recommendations based on CDC and/or WHO (World Health Organization) international travel guidelines.
- *Targeted vaccine distribution:* Institutions must be prepared to participate with state and local health departments in vaccine distribution efforts to pre-determined priority groups.
- *Essential personnel, operations, and services:* Colleges must be able to identify the personnel, operations, and services that will be essential to keep the institution functioning and carrying out its basic responsibilities. Depending on the school, this will include things related to human welfare, animal welfare, research, and teaching.
- *Surveillance and case investigation:* Participation in surveillance and case investigation activities with clinical and state and local public health partners will

“The areas in which the Health Service should be particularly involved education, surveillance, triage, provision of medical care, and referral.”

be essential to ensure that human and animal cases are quickly identified and addressed.

- *Health care:* Plans are necessary to assure that clinical resources are available to meet the outpatient health care needs of students, faculty, and staff. This will include on-going health care needs in addition to those precipitated by an influenza outbreak.
- *Mental health:* The mental health issues that will arise from a pandemic influenza outbreak will require individual and community-wide interventions. Appropriate resources need to be in place to meet this need.
- *Student housing:* Plans need to be made on how to care for students who will not be able to return to their own homes during a pandemic. Plans must also consider the possibility that vacant residence halls could be used for quarantine and as infirmaries.
- *Communications:* Timely and accurate information will be vital to all stakeholders if they are to adequately address the challenges of a pandemic influenza outbreak.
- *Internal coordination:* Coordination and decision-making responsibilities within the college/university must be clearly defined in order for the institution to appropriately and effectively respond to an outbreak. Decisions should be made based on clearly defined and agreed upon criteria.
- *External coordination:* Plans need to be in place to effectively coordinate with state and local health departments, local emergency managers, hospitals, and clinics.
- *Relationships to the broader community:* Depending on the size of the college/university and the expertise within the institution, plans need to be in place on how to share staff, resources, and expertise with the broader community.

Role of College Health Services

While the titular leaders of the college/university must assume ultimate responsibility for addressing the issues outlined above, the Health Service can play a significant role in the development of an overall college/

university pandemic influenza plan. Because of their public health role and their clinical resources, college health services should be part of the institutional, health care, and community planning efforts.

Depending on the resources on campus (emergency management office, academic medical center, etc.), the leadership and responsibility roles of the Health Service will vary. However, input from the Health Service will be crucial in the development of a plan that is workable and effective in case of an outbreak.

The areas in which the Health Service should be particularly involved include: planning and coordination, communication and education, surveillance, triage, provision of medical care, and referral.

1. Planning and coordination

Since planning for pandemic influenza is beyond the capacity of any single agency, collaboration and coordination of resources is essential. College Health Services are uniquely situated to be able to determine how on-campus and off-campus agencies can coordinate the use of their resources to best serve the college population. In addition, being part of the community discussions helps Health Service personnel learn about who is responsible for what and the status of community planning and recommendations.

Because all resources will be stretched thin, the Health Service needs to determine whom they will serve during a pandemic. Consideration should be given to expanding the role of the Health Service during this time to serve faculty, staff, and the general population, in addition to students. One possible scenario leaves the campus devoid of students during a pandemic so the Health Service may have the capacity to help serve other community members.

As part of this overall planning and coordinating effort, determinations need to be made by all involved about how to deal with the absenteeism that is sure to occur, how to credential providers who may be working in and with other agencies, and how to manage the on-going routine health care in the face of a pandemic.

2. Communication and education

In addition to the general communication that will need to occur among colleges and federal, state, and local public health officials, timely and focused communication with college staff and the general college community will be crucial. In particular, Health Services will need to communicate with employees about staff availability and about what they should be doing if they come to work. Part of this communication will include pertinent and factual educational information about the disease and the status of the outbreak.

Communication with the general college community will be a critical piece of a pandemic influenza response plan. The more information that can be provided to the community about WHO/CDC guidelines, the status of the outbreak, how to use the system, how to do self-assessments, and provide self care, the better the health care system will be able to handle the demand for services.

Health Services will be able to help with communication by having telephone systems in place to handle increased demand. Health Services should also be able to communicate through e-mail with all students and staff and have the capacity to provide information over dedicated Web pages. Linkages to other information sources will also be helpful.

3. Surveillance

Health Service should have a mechanism for determining the active health issues currently on campus and whether they are growing in number or intensity. This surveillance should be both clinic-based and campus-based. Clinic surveillance includes being aware of changes in diagnoses being seen in the clinic or increases in numbers of people seeking services for particular symptoms. Campus-based surveillance will require close communication with residence halls, recreational sports facilities, student unions, academic units, and other places where students spend a lot of time. Using peer educators could be one way of developing this surveillance capability.

4. Triage

One of the most important functions that a

Health Service can provide during a pandemic influenza outbreak is triage. With large numbers of people getting sick, triage will become increasingly important as a way to keep the system from getting overrun with people seeking services. To be most effective, as much triage as possible should be done through non-face-to-face encounters. Telephone, e-mail, and Web-based triage should be rapidly expanded at the first sign of a pandemic. Protocols need to be developed and staff need to be trained in how to use those protocols. Staffing of this function will be critical.

Clinic-based triage will also be of high priority. Screening, assessment, patient flow, education, and respiratory protection protocols need to be in place for this to be effective. Mass-triage, if needed, will most likely have to be coordinated with other public health agencies and medical providers.

5. Health care

Given that one of the major responsibilities of college Health Services is to provide health care to students, this is an area where college Health Services obviously need to take a leadership role. Even on campuses where there is an academic medical center, Health Services will have more expertise in providing ambulatory care than anyone else. This care will need to be coordinated with other providers in the area, especially as the numbers of people seeking services increases.

Staffing, patient flow, and treatment protocols will need to be developed. Masks, gloves, hand sanitizer, and other infection control supplies will need to be stockpiled in preparation for a pandemic.

If residence halls are available and used for quarantine or as infirmaries, Health Services will most likely be called upon to provide health services to these facilities. While most Health Services aren't currently equipped to do this kind of care, collaboration with public health agencies and local hospitals may facilitate the delivery of this kind of service. Similarly, college facilities may be needed for mass clinics and mass dispensing sites. If this becomes necessary, Health Service collaboration with other community agencies will be required.

“Because of their unique needs and their importance to the communities in which they are located, colleges and universities must be an integral part of the planning for a potential pandemic influenza outbreak.”

The threat of pandemic influenza should also initiate a discussion about adding a public health nursing component to health services. Public health nurses would be invaluable in dealing with the kinds of educational, home care, and infirmity issues that will arise with a pandemic influenza outbreak.

6. Referrals

In a pandemic influenza outbreak, the resources of the Health Service may be quickly overwhelmed or patients may be too sick to be treated at the Health Service. Having referral guidelines in place will facilitate the movement of patients to the appropriate level of care. However, during a pandemic, usual referral sources may also be overwhelmed. Monitoring of the availability and accessibility of community resources will be an on-going need.

Role of Academic Medical Centers

While this article has mostly focused on the role of college Health Services in responding to an outbreak of pandemic influenza, campuses with an academic medical center will have additional roles and responsibilities. Academic medical centers are community resources. They generally have hospitals and clinics that can help add to the medical surge capacity of a community. They also have large numbers of personnel with particular skills and expertise that can be used to help provide clinical care or consultation. In addition, they have students in many disciplines who could be used in some capacity, if necessary.

On campuses where there is an academic medical center, the collaboration between the college Health Service and the medical center is crucial. Each play a different role, but each complements the other. Their ability to work as a team will be important if the response to a pandemic influenza outbreak is to be most effective.

Conclusion

Because of their unique needs and their importance

to the communities in which they are located, colleges and universities must be an integral part of the planning for a potential pandemic influenza outbreak. They need to be working with state and local public health agencies, local emergency management programs, and hospitals to ensure that services are coordinated and that the needs of students, faculty, and staff are adequately addressed. For these plans to be most effective, college Health Services and academic medical centers should be part of the planning efforts.

While they may or may not take the lead in pandemic influenza planning, college Health Services do have an obligation to point out what needs to be done and help facilitate the development of appropriate policies and protocols. It is expected that a pandemic influenza outbreak will occur at some time. College Health Services, as part of their public health mission, should be ready to respond with appropriate speed and competence.

Acknowledgements: Some of the information used in this article came from a surveillance study being conducted by the author in collaboration with Kristin Nichol, MD and Sarah D’Heilly. Additional information came from the University of Minnesota Pandemic Influenza Preparedness Workplan developed by Jill DeBoer, Director of the Academic Health Center Emergency Preparedness Program.

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Teaming Up to Address Health Disparities: The University of Maryland's Healthy Workers Program

Sacred Bodison, MD, MBA, University of Maryland

The University Health Center, at the University of Maryland, College Park, developed the Healthy Workers Program (HWP) to address undiagnosed and untreated chronic illnesses among a group of hourly employees without health benefits. In 1999, Health Center staff identified a need for basic health services and health promotion for the medically underserved employees of Dining Services. Over the past six years, the HWP has become an outstanding example of how health service's staff, student volunteers and other employees can work together to improve health outcomes.

The program targets approximately 350 food service employees who have no employee benefits. Consistent with Healthy People 2010 objectives, the goal of the HWP is to diminish health disparities and improve access to care and the quality of life among a group of medically underserved on campus. These workers, 99% of whom are minorities and 80% of whom are women, present with complex needs and multiple barriers to care including dual diagnoses, low literacy levels, low English proficiency, poverty level wages, and limited transportation.

Furthermore, this population of largely Hispanic and African heritage workers has a high incidence of chronic illnesses such as diabetes, hypertension, asthma, and hyperlipidemia. The most cost-effective and time-efficient strategy for reaching this population has been to bring health care and health education to the worksite; not interfering with employees' other commitments, including second jobs, child-care, and transportation arrangements.

The University is located in suburban Washington, DC, where a paucity of health care services exists for the uninsured. The HWP provides a medical home for the employees who come from the surrounding area. Additionally, the program staff negotiates with community providers to provide specialist care at a lower cost and assists program participants in navigating the limited community resources that are available for pregnant

women and children. The HWP staff identifies and enrolls employees in state-funded indigent cancer screening programs, some conducted at the Health Center.

The Dining Services Administration has supported the program because they feel their employees in the HWP are healthier, take less time off from work due to illness, and have better morale. A University foundation account was created to allow contributors to make tax-exempt donations in support of the service. Pharmaceutical costs are controlled by using a limited formulary and pharmacy assistance programs. The employees pay a co-pay of \$3.00 for prescriptions; other care is available at no cost. Pharmaceutical samples and donations of blood glucose meters have been beneficial. The Health Center or the Department of Dining Services sponsors an annual fund raiser. The HWP has received grant funds in the past to address health issues such as smoking. A future goal is to obtain funding to collect longitudinal health outcome data on participants in the HWP.

The HWP's unique service design includes wellness, prevention, acute care, and treatment of chronic illnesses. Worksite screenings regularly detect new and poorly treated chronic conditions, such as diabetes and hypertension. Health education topics include nutrition, foodborne illness, smoking cessation, dental care, and HIV. A part-time internal medicine specialist is dedicated to the program. The Health Center donates access to ancillary services, such as physical therapy, laboratory, radiology and orthopedics. Outreach events are scheduled during less busy days at the Health Center and are staffed by nurses, medical assistants, practitioners, and occasionally medical residents or nurse practitioner students. Fall outreach clinics are focused on providing Flu vaccinations, and making sure employees know how to make appointments for care at the Health Center. Three additional outreach clinics, conducted in the major dining facilities later in the academic year, offer health screening and education on relevant health topics.

At least 632 patient visits to the Health Center occurred last year. Employees presented with a variety of chronic and primary care ailments, including back pain, headaches, allergies, upper respiratory infections and gastrointestinal problems. Many employees stand during their entire shift, which leads to foot and back problems. Helping employees protect their feet and use proper lifting technique is a focus of patient education. One participant described the benefits of the program: “[The HWP is an] excellent program that has helped me a lot. I really appreciate it. I didn’t know I had high blood [pressure] until this program discovered it during a check up. I feel more at ease and this makes me less tense at home. It comforts me to know I have some place to go when I have a problem.”

Needs assessment surveys are done periodically to determine what issues are most important to the employees. The student volunteers develop 20-minute presentations relevant to these concerns for small groups of employees during outreach clinic events. The information is presented in English and in Spanish. Employees who have health benefits are welcome to attend the health education sessions.

Bilingual student volunteers team up with Health Center staff to ensure culturally sensitive primary health care services. The fifteen student volunteers in the program come from a variety of majors, with most aspiring to work in the health field or to use language skills in the future. Students are recruited via word of mouth and classroom presentations. A professor in the Department of Public and Community Health volunteers in the program and invites HWP volunteers to speak regularly in his classes. The program provides the students with medical interpreting and HIPAA training

The HWP office is staffed nearly 40 hours per week with the bilingual students, who assist with interpreting for patients receiving services in all units at the Health Center. The volunteers are called or paged when interpreter services are needed. Most volunteers interpret for Spanish speaking patients, but a few speak Amharic or French Creole. In addition to interpreting, the students translate written material, make appointments, help patients enroll in pharmacy assistance programs, and give health education presentations. Though the Health Center Director has overall responsibility for the program, the HWP office is managed by an experienced student volunteer working closely with a program management specialist from the staff. Each spends several hours per week organizing program activities and assisting with interpreting. All

management staff and volunteers meet periodically to discuss program goals and make assignments.

An amazing benefit of the program has been the impact of the service learning experience on the student volunteers. Most spend multiple years with the HWP, citing immense personal gratification. The students gain practical experience in presentation skills, leadership skills, and knowledge of public health issues for immigrants and the uninsured. One student volunteer describes her experience: “I am a community health major, but I am thinking about nursing. I like the fact that I am able to do something positive for the Latino community. As a Latino student, I know that I am lucky to have the opportunity for an education.” A second student states, “I am a cell biology major and pre-med. The program has allowed me to connect with another part of the University to which otherwise I would not have paid attention. I feel I have a personal relationship with the employees and see them differently. Volunteering in the HWP has given me a great opportunity to see how patient care is conducted. It combines clinical service with the social aspect. I have a deeper appreciation of how culture and lifestyle can affect illness. Now I intend to pursue an MPH along with my medical degree. From the HWP experience, I can see how it is possible to conduct community research projects and collect biostatistics. My improved Spanish skills will help me immensely as I would like to practice in an urban teaching hospital.”

A number of the graduates now work in community non-profit organizations doing similar work, and several are in medical school and/or pursuing a masters degree in public health. The student volunteers have donated money to the HWP tax-exempt foundation as well as assisting in fundraising projects. A few students receive academic credit, using the HWP as an externship or internship experience.

The Health Center is fortunate that its staff and students are willing to reach out and assist medically underserved individuals in the campus community. The employees benefit and the students receive an enlightening, if not life-changing, service learning activity that integrates real-life issues into their higher education experience.

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BRIEFLY NOTED...

One of the themes the participants at this year's Leadership Forum identified as critical to the future of Student Health was integration into life of the university. Another topic of interest and concern was abuse of alcohol and other drugs.

We are indebted to Jim Yankech at the University of Nebraska at Lincoln for calling to our attention two recent publications on Engaged Learning, which address both issues – the integration of student health and abuse of alcohol and other substances. They are:

- “Substance Abuse, Mental Health and Engaged Learning: Summary of Findings from CASA's Focus Groups and National Survey” – Funded by Sally Englehard Pingree and The Charles Engelhard Foundation.
- “Linking Engaged Learning, Student Mental Health and Well-being, and Civic Development: A Review of the Literature” – Lynn E. Swaner, EdD, NCC

While a crisp definition of “Engaged Learning” is not provided in either paper, the core concepts are service learning, collaboration with faculty, personal responsibility, and “problem-based learning, the study of complex, real-world problems.”

Two points are striking from both these reports:

- First, while most students reported that some faculty seemed to truly value their input, two thirds said, “They have rarely or never had a course with a service learning component” and, “rarely or never worked closely with a faculty member on a research project, independent study or internship and felt their input was valued.”
- Second, “students who report being more engaged in their education and in service activities are significantly less likely to smoke, drink, or use drugs.”

The report acknowledges that many factors influence students' risk behaviors:

“Clearly, many forces influence students' risk for depression and substance abuse; most of these — including students' personalities, peer relations and family dynamics — are largely beyond the scope of colleges and universities. However, one area that has thus far received relatively little attention and that it is within the purview of colleges

and universities to influence is student engagement in their academics and in their surrounding communities and environments.”

All this raises an important question about Student Health 2010 and the theme of integration. Anecdotally, when Student Health Service directors are asked how integrated they feel their work is with student affairs, on a ten point scale, they usually report five or higher. When asked the same question about their integration with the academic faculty, the response is typically four or lower.

If engaged learning can be seen as a health promotion activity, it may well be worth some advocacy from Student Health.

And, just as we were going to press, we received a long congratulatory letter on the last issue from Donald W. Harward, President Emeritus of Bates College and Project Director of “Bringing Theory to Practice: a Project Addressing Depression and Substance Abuse Among Youth (ages 15-25) Through Engaged Learning and Service.” The Project supported the research cited above.

“The Bringing of Theory to Practice (BTtoP) Project is a national initiative formed in partnership by the Charles Engelhard Foundation of New York and the Association of American Colleges and Universities. Now in its third year, the Project is committed to exploring and advocating the academic community's interest, support and valuing of engaged student learning and its relationship to the mental health and civic development of individuals and their communities.”

“Approximately \$2.5 million has been raised from private foundations to support the work of the Project; these resources are then made available in the form of grants to campuses. Over two hundred colleges and universities are now linked to the Project; nearly 40 institutions received grants this past year from the Project for research or to initiate a campus-based program.”

“Readers of *Spectrum* can receive information about the Project by contacting the Project directly (Jennifer Wong, Program Associate, at wong@aacu.org). More general information may be found on the website (www.bringtheorytopractice.org).”

PUBLISHED BY THE CHICKERING GROUP

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