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MANAGING CHANGE IN STUDENT HEALTH

Editorial

Thoughts on Organizational Change

When the Editorial Board of *Spectrum* met last June at ACHA they selected "Managing Change in Overlapping Communities" as the topic for this year's Leadership Forum. Leading up to the Leadership Forum meetings, several people called or wrote with both questions and suggestions about how we might get our hands around such a complex topic. Participants worried about changing roles with the addition of new public health responsibilities; the challenges of ever increasing demand for mental health and behavior health services; the uncertainties driven by changes in leadership at various levels of the university; changes driven by data, particularly sources like the NCHA; and changes driven by new technology – both information and communications. Student safety was also on people's minds, as were the changing expectations of parents.

Listening to these questions and concerns before we convened, it occurred to me that perhaps a pre-read on the broader issues of institutional change might be helpful. What follows is what I sent out to participants a week or so before our meetings.

Scale and Timing

Organizational change may be conceptualized on two dimensions: scale and timing. Large scale change can occur quite precipitously, as we recently saw with the UAW bargaining which created a huge VEBA (Voluntary Employee Benefits Association) to manage health benefits. By contrast, changes initiated decades ago by Surgeon General Luther Terry to decrease smoking are still finding their way through institutional change, public policy and cultural values. More recently, Surgeon General David Sacher's efforts to reduce racial and ethnic disparities have yet to find real traction.

Small scale changes can also happen quickly, as with the adoption of an Electronic Health Record, or more slowly, as with efforts to look at practice pattern variation or to implement drug utilization review.

As a general rule, change which involves public policy, multiple constituencies, and changes in individual and/or group behavior will occur more slowly. Changes which are externally driven (e.g. budget cuts), mission-critical decisions (e.g. integration of counseling centers into health services), and facility changes (e.g. new buildings, renovations, or moves) will move more rapidly, often driven by a clear end point.

Whatever its scope and scale, change is a constant dynamic in organizations, driven by changes in the institution's mission, its constituencies, leadership, resources, technology, morale, and the metrics by which its success is measured.

Lesson: Be realistic about how long a change process will take. For long-term change efforts, try to set realistic intermediate goals at six to nine month intervals.

Establishing a Culture of Change

The "healthy" organization embraces change as part of organizational vitality and responsiveness. Adaptability is seen as a core value.

A key to embracing change is the empowerment of staff at all levels to say, "This could work better if…" or equally important, "Why do we do this at all?"

A key to empowerment is encouraging people to make decisions where the data are and where these people are accountable for that part of the organization's success. One reason many large (and frequently public sector) organizations struggle with change is that their culture pushes decisions up several levels above where the data exist to make those decisions. In 1982, I was working on a project on public sector executive functions and I discussed this observation with Hale Champion, at the time Executive Dean at Harvard's Kennedy School and former Under Secretary of Health Education and Welfare (now HHS) under President Carter. He told me, "When Joe [Califano] and several others of us were running HEW, we had

"Whatever its scope and scale, change is a constant dynamic in organizations."

virtually no time to be reflective, to think through policy options and to plan. We were working 14 - 16 hours a day just to keep the department going. While we tried to structure it differently, we often could not succeed because the accountability structure in the public sector will not accept delegation, even where the variance in management inherent in delegation would make no difference. You can pick up the paper daily and read about public officials being called to task for delegating decisions that deviated slightly from the perceived path of perfect implementation. Thus you have the anomalous situation where there is no big picture, long-term accountability (except for history), while narrowly the public sector demands perfect equity."

Critical in establishing a culture of change through an empowered workforce is driving home the point that most changes will have some broader impact – within their area of responsibility, often within other parts of the organization and usually to some degree on individuals and groups external to it. This is particularly true for changes in information technology, which usually requires data feeds from multiple sources and where multiple end-users exist. Systems changes also deserve particular attention because systems don't do things one at a time. Not only are systems tests critical, but communications among all data feeds and end-users are essential.

A culture of change has many attributes. Consider these seven:

• Change is both essential and constant in successful organizations. The question of, "How do we become better?" is the norm.

• Individual empowerment is a license to question the status quo, suggest changes, and collaborate, but not to initiate change on your own. A culture of change encourages group problem solving and discourages "Lone Rangers".

• Problems are faced promptly and honestly without blame. Ad Hoc and "work around" solutions are discouraged.

• "People" problems and structural and system problems are kept separate.

• All organizations need some degree of stability. Change management must be balanced with the need to keep the organization moving forward on familiar and solid ground. One or two change initiatives are about the limit for most organizations.

• All change should be part of an ongoing strategic plan. Even a dramatic, external "shock" change (e.g. loss of major grant support) will need to be digested into a plan. As Yogi Berra, the management consultant from the NY Yankees said, "If you don't know where you are going, you will end up someplace else."

• In a culture of change, all change will have clear measurement metrics associated with it.

Change and Conflict

Change will always generate some conflict. Crudely differentiated, these conflicts are either pre-existing conditions where the change is an excuse to bring them forward; that is, the change is a precipitating, but not causal, factor. The second and quite valuable conflict is about the substance of proposed change itself.

Most people are more comfortable with the status quo and will resist change by creating some conflict. That conflict can have real value in bringing both legitimate concerns forward, but also in identifying interpersonal resistances. The trick is to acknowledge and embrace conflict as a valuable part of the change process. The leadership challenge is to depersonalize the conflict to try to get quickly to the substantive issues. Also, if you know your people reasonably well, you should be able to anticipate problems which are pre-existing problems and deal with them so that they don't confuse the change process. As one of my mentors said, "The goal is to build an organization where you have all of the necessary fights."

An example: As an SHS moved to adopt an EHR, the Director knew that the one physician who was currently using 25% of dictation transcription time would argue that the EHR would unduly limit that physician's ability to adequately record essential clinical notes. The issue, of course, was not the EHR, but rather the physician's inability to write a succinct clinical note. Ideally, that performance issue would be dealt with prior to the EHR implementation. If allowed to be tied to the EHR, the substantive question of free form clinical notes within the EHR would become confused with that one individual's pre-existing performance problem.

There are four lessons to be learned about the management of conflict during change:

- First, unresolved issues will often surface in a "Change" situation.
- Second, acknowledge the substantive questions, but decouple them from performance issues. Never deal with the performance questions publicly.
- Third, use and encourage humor in your management style. In Shakespeare, the fool was always the wisest character. The reason: the jester was the only person who could tell truth to power. Listen to the jokes; there is a good chance there will be useful messages for you.
- Fourth, full participation and open debate should not lead people to think there will be group decisions or a democratic process where the majority rules. The leadership role includes listening to all opinions, making difficult decisions, and then selling the decisions. If everyone is happy, the chances of meaningless compromise are high.

Leadership in Change

Shortly after former Treasury Secretary W. Michael Blumenthal left government, he commented in a *Fortune* interview, "Another example of how...different that [managing change] is in government as compared to in a corporation – has to do with the risk of changing your mind. A businessman is entitled and expected to change his mind, and there is no particular approbation attached to that at all. You get new facts, conditions change, the markets change, industries change, you get a new contract or you lose one, you talk to more people...What counts in the end is how you come out, not whether you've changed your mind or not. In the government, if you change your mind, you're accused of inconsistency. That's one reason there is a lot of doubletalk in Washington."

It may not be hard for some in higher education to think the Secretary's comments about government could easily apply to higher education. That is not the relevant point. The point is, we all live in a changing world and leadership that is appropriately responsive to change is what is critical.

At last year's NECHA-NYCHA meetings, both Hugh Tilson, from the School of Public Health at Chapel Hill, and Angus King, the former Governor of Maine, spoke about leadership and change management. The following is my distillation of their key points:

1. Leaders know their organizations well, know the organization's context well, and know the best practices in their field.

Lesson: You can and should delegate work and its associated authority. You cannot delegate your understanding of what that work is and how it relates to the rest of the enterprise, particularly customers.

2. Be honest about what the options are and what degrees of choice exist. Don't set up phony meaningless choices, as with a young child, "Do you want to go to bed at 8 or 8: 15?"

Lesson: To be honest about options, you have to do the work to know that yourself. Budget cuts often tempt one to rally the troops to prove to the budget czars that terrible things will happen if the cuts go through. This is a dangerous and often destructive strategy. We all live in organizations with limited resources. Working within those limits and identifying new resource opportunities is the ongoing assignment.

Salman Rushdie, in one of his early novels, said, "The most profound changes in one's life often begin *priately responsive to change is what is critical.”*

when you are not around.” We all have changes imposed on us. Our job is to adapt as best we can.

3. Open a “bank account” of trust and respect and make frequent deposits. Managing change will require some amount of personal capital.

Lesson: This is less about popularity and more about fairness, thoroughness, thoughtfulness and willingness to make decisions. It starts at the beginning, which is the reason many elected executives are evaluated on their first 100 days. Knowing and appreciating all aspects of the organization’s work is important. Governor King described asking to ride on a State Highway Department snow plow during the first big snow of his administration. He said, “I had a ball, and the word went out across all state employees, this guy is interested in what we do.”

4. Avoid surprises, for your superiors, your colleagues, and the populations you serve. There are very few requirements for change that could not have been anticipated.

Lesson: If you are surprised, do two things. First, to the degree possible, digest it and take as much of the “surprise” out of it before communicating with your staff. Second, ask the hard question, “Why didn’t I see this coming?”

5. To paraphrase Franklin’s comments about house guests: “Decisions are like fish.” Left unmade they become quite unpleasant.

Lesson: You’ll never know everything. Figure out when you’ll know enough to begin something useful. Usually, midcourse corrections are acceptable, including starting over.

6. Communication and Attitude. Angus King offered these quotes on the management of change.

- “I deal in hope,” Napoleon
- “Failure is not an option, you cannot spread uncertainty down the line,” Ed Krank, Apollo 13 Mission Control
- “If the trumpet is uncertain, who will follow?” Old Testament
- “Success is moving from failure to failure without losing enthusiasm,” Churchill

7. Leaders have three kinds of authority:

a. Statutory: “Because I am the boss!”
b. Knowledge, expertise, and experience
c. Character and integrity

Someone of great integrity who is knowledgeable, thoughtful, inclusive and decisive will outrank title and position in terms of leadership. As Heraclitus said, “Character is Destiny.”

In summary: We all have managing change as an essential part of our job.

Why? Because as Will Rogers explained, “Even if you are on the right track, if you just sit there you’ll get run over.”

So what to do:

1. Build a culture where change is both the norm and is welcome.

2. Empower staff at every level. Coach and support, but let them run their parts of the organization. Above all, know what’s going on and how the connections among interdependent parts of the organization are working.

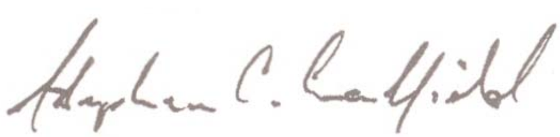
3. Make decisions based on knowledge, but when you know enough to do something useful, do it.

4. Some bad decisions will be made. No problem, unmake them and take responsibility. Undo bad decisions completely, don’t try to fix something that is fundamentally flawed.

5. On the good decisions – pass the credit around.

And, in listening to this years participants, and in reading the several supporting articles in this issue, it is clear that there have been and will continue to be many good decisions, so there is much credit to be passed around – passed around not only to those identified in this issue of *Spectrum*, but to all of you in higher education contributing to the health and academic success of your students.

Keep up the good work,



Stephen C. Caulfield, MSW
Chairman, Chickering Group)

Managing Change in Overlapping Communities

Stephen C. Caulfield, MSW, The Chickering Group

Editor's Note: In November 2007, forty leaders from thirty-six colleges and universities met in two locations to discuss "Managing Change in Overlapping Communities," a topic selected by the editorial board of Spectrum at their annual meeting at ACHA. The discussions which led up to the selection of this topic included:

- *Student Health Service Directors and their staffs are increasingly seen as the Chief Public Health Officers for their campuses. Pandemic and bioterrorism planning have cast them in the role of both leaders and change agents along with having the responsibility to provide service.*
- *The growing demand for behavioral and mental health resources has challenged Student Health, Student Affairs and behavioral and mental health leaders to address resource allocation.*
- *Issues of accommodation, medical withdrawals, and admissions criteria have challenged Student Health leadership to manage the changing disease and disability burden of their student bodies.*
- *The growing interest and increased questions from Student Affairs regarding health promotion and disease prevention are creating new working alliances between Student Health and Student Affairs.*
- *Data driven decisions (with particular reference to the National College Health Association [NCHA] data) often are driving programmatic change.*
- *Information technology is requiring changes in Student Health Service practice, scheduling, and resource allocation.*

This summary of the Leadership Forum's participants' views on managing change will integrate the comments from the two meetings.

The Changing Role of the Student Health Service Director

The discussion opened with several participants commenting on the evolution of their roles over the past few years.

Since HIPAA, I have seen my role expand from Director of our Health and Wellness Center to the University's Health Officer. With this increase in responsibilities has come increased recognition, but not necessarily additional resources.

Estelle Maartman-Moe, RN, University of Vermont

There is no question that our jobs are changing. We don't see change as one person's responsibility; it is the job of the whole team. A well-functioning team will adapt, while a team that is even slightly dysfunctional will be challenged by change.

John Andrews, MD, MPH, University of Cincinnati

Change can energize both individuals and the organization. Because of our training and experience, medical professionals are usually more flexible and adaptable. The emergency medical model of triage, diagnosis, and treatment can be very useful in managing change.

Gerri Taylor, MS, APRN Bentley College

Many of us may have significant changes imposed on us. Our challenge is to manage those "mandates" and try to make the necessary and appropriate mid-course corrections. At Howard, we are now being asked to move the primary care capacity of student health into the faculty practice plan – in part because the plan is dominated by specialists and sub-specialists who need primary care to keep referrals flowing. The University's assessment that we may have excess primary care capacity is fair based on current utilization statistics, but their solution to move all our primary care physicians to the faculty practice plan would totally change our model of student health care.

Lynette Mundey, MD, Howard University

Credibility with the medical school faculty, particularly the Department of Family Medicine, where I have an appointment, has been useful to me. I'm not suggesting the model they are proposing at Howard is the right one, but in my short tenure running the SHS at Boston

"We all face external changes...My approach is to try to understand what opportunities may exist in these changes first, so I can present the positives to my colleagues."

– Evelyn Wiener, MD, University of Pennsylvania

University, my credibility and presence with Family Medicine has been very helpful.

David McBride, MD, Boston University

Change is often driven by either power or money…or both. I have tried to avoid seeking power by being seen as an expert – I think there are too many risks in becoming the "Surgeon General" of the campus. If you become seen as a powerful figure (ie "a parent"), I think you may lose your ability to help the students with the greatest need.

At Case Western Reserve, with multiple administrative changes, we have had practice in making explicit how our goals for students align with those in new positions of power. One example: our new president has student safety as a priority. That gave me a great opportunity to tell her about our participation in Henry Chung's Depression Collaborative, whereby we are now screening all of our primary care patients for depression.

Nell Davidson, MD, Case Western Reserve University

In addition to power and money is the growing pressure from parents to assume their roles – the 2007 version of "in loco parentis".

Glenn Egelman, MD, Bowling Green State University

I agree about the parental pressure, but I think everyone in student health should avoid assuming the parental role with students. The moment you take on that role, you lose the opportunity to establish a therapeutic alliance with your patient. While I would hope we share the 'best interest' of the child with the parents, our relationship is primarily with the student.

Nell Davidson, MD, Case Western Reserve University

The Student Health Service is one of the few campus institutions that has a working relationship with almost all University departments including Student Affairs, Judicial Affairs, Admissions, as well as faculty and staff. These relationships provide it with considerable political capital and the ability to serve as change agents.

John Andrews, MD, MPH, University of Cincinnati

We all face external changes, although not all as significant as Lynette's. My approach is to try to understand what opportunities may exist in these changes first, so I can present the positives to my colleagues.

Evelyn Wiener, MD, University of Pennsylvania

Spectrum: Can we talk about the changes that have come about in your roles as a function of taking on more public health responsibilities?

The potential for the University to be a significant player in public health became clear in Bloomington in 1982 when there was a major outbreak of measles. The State Department of Public Health was involved, as was the CDC. As they were thinking about containment options, including quarantining the town, it dawned on them that the population of Bloomington was 50,000 and there were 39,000 students at I.U. From that time on, we've been a central part of all public health initiatives. The core question, of course is from where do the resources come?

Hugh Jessop, PhD, Indiana University

I may be the exception, but I have had considerable success in using externally driven change to get additional resources. When the State Department of Public Health recognized that we were larger than 90% of the towns in the state and asked us to assume a more active role in pandemic planning, I was able to present that request as a opportunity for the University and, as time went on, to use that town-gown positive role to support specific request for resources.

Estelle Maartman-Moe, RN, University of Vermont

I agree. My initial response is to "take it on" and try to develop both political capital and sell the need for whatever additional resources may be required. But, whatever you do, you cannot lose sight of your primary revenue source, which is caring for students.

David McBride, MD, Boston University

We are in a similar situation with our campus of 55,000 and growing. It is critical to understand that in public health matters we are part of a larger team on-campus, one important member of which is Public Affairs. If you have one or two cases of MRSA in the current environment, your first call probably should be to Public Affairs.

Allan Markus, MD, Arizona State University

TCU has built four new residence halls with two opened in August and the remaining two scheduled to open in January. The University's goal is to house two-thirds of the undergraduate population on-campus. In addition to the residence halls, a new Student Union is under construction and is expected to open in August of 2008. We are becoming a 24/7 campus, so not only are there pressures on us to expand our access for direct care, but also to take on a greater public health role. TCU has been designated as a "Point of Distribution" by FEMA, with our new Director, Dr. Rae, tapped as the Medical Director of the POD. In conjunction with this new responsibility, Dr. Rae has had the Health Center staff participate in the Emergency Medical Corp training.

Marilyn Hallam, Texas Christian University

How many of us have a large tent which we can use for triage in the event of pandemic flu or something like that? I ask because it is a nice concrete example of asking for specific resources. We do not, but have put in a budget request to get one so we can set up on the parking lot next to our Center if we need surge capacity space.

Ira Friedman, MD, Stanford University

The 109 community colleges in California are, by law, required to have a public health nurse head up the SHS. Our challenge, not only for public health needs, but also for many of the basic health care needs of our students, is to find resources in our communities which are either free or sliding scale to care for our students. In our circumstances, the public health resource problem seems to be the easier one to solve because of clearly identified public health organizations at the county and state levels.

Susan Quinn, MSN, APRN, Santa Rosa Junior College

Change Driven By a New Health Service Director and a Commitment to Evidence-Based Practice

I was brought in as the Director of a SHS last year where the only slightly-veiled mandate was to determine whether the Student Health Service should be out-sourced to some independent health care organization. There were three major problems with the existing program: patient satisfaction was very low, the program was running with a large deficit, and the physical plant was outdated and inefficient – a 1950's building which had not had any significant renovations.

Because I came from "outside" as a Director of Residency Training, the Vice President for Student Initiatives trusted me to take an objective look at all possible solutions. In this kind of situation, you have to make a fairly quick assessment as to whether the existing program can be saved, or if outsourcing is the answer. If you wait, what talent you have on staff will leave. I decided we could save the program and quickly enlisted the staff in that process. We started by setting some six-month goals: patient satisfaction had to be 97%, and we had to show significant progress toward that goal. We had to improve our billing and collection process from insurance and reduce our debt significantly. We had to revamp our scheduling system, use our EHR and develop metrics for the efficiency and appropriateness of care.

As we developed these goals and made it clear that things were going to change, some of our people left, including three or four clinicians.

What did we achieve in these first months? Patient satisfaction jumped seven points. We reduced our deficit from $800,000 to $500,000. We established a "Positive Performance Fund" which tied bonuses to patient satisfaction and the degree to which our staff "embedded themselves in the University," a somewhat difficult metric to quantify, but important because I felt it was essential for us to be truly part of the "business." We established a "Student Health Care Task Force" which looked at what resources in the community we could partner with to provide better service and found there were few. We established evidence-based practice guidelines on things like appropriate antibiotic prescribing using strep as a starting point. We used the established criteria for ordering a rapid strep test (all four criteria: treat, no test; two or three criteria: rapid strep test; one criterion: don't treat) and we audited against these standards.

After six months I would say morale is good and people are uniformly working hard and enjoying themselves. We have adjusted our goals to also include having an impact locally and nationally, to participate in benchmarking, and to develop on-campus and in the community a network of "living well" resources.

We are a large campus with 55,000 students on the Tempe campus and 10,000 in other locations. We are building 10,000 residential beds each year with a plan to grow to 90,000 students over the next several years. The public health opportunities are huge. The University is creating "neighborhoods" where students with similar interests will reside. We are putting nurse practitioners in those "neighborhoods" to provide some primary care, triage sicker students, and be a resource for health education.

Our challenges are significant, but everyone now thinks we are up to the task. We have an excellent team with the COO, the CMO and I involved in all key decisions. I have kept my hand in both teaching and direct clinical care one day each week. And, I have remained active in the local medical community.

These changes have been significant, but have had an energizing effect on all involved. My goal throughout has been to be clear about both our goals and how we can achieve them: to be sure we have both the right people and the necessary resources to do what's required, and to encourage everyone to stretch, but to know that stretching is not life or job threatening. It sounds contradictory, but I've tried to make it safe to take the risks necessary to change.

Allan Markus, MD, Arizona State University

To pick up on just one of your many valuable points, adherence to evidence-based guidelines, I have found talking about the data is a very effective way to improve our adherence and efficiency. I am also a new SHS Director, and also from the "outside," although I was on the faculty of our medical school. When I began to look at how we were treating UTIs, a relatively high-frequency diagnosis with about 1,600 cases a year, although the guidelines are clear, for some reason we were not adhering to them. When you look into why guidelines are not followed in other practice settings, the single biggest reason is the clinicians do not feel they had a voice in developing those guidelines. When we examined the appropriateness of the guidelines for our population, and involved our staff in looking at our data and monitoring our adherence, our use of the guidelines went way up.

David C. "D.C." Dugdale, MD
University of Washington, Seattle

We have done a similar exercise with similar results, but then staff changes, time goes by and we all become a bit lax, thinking every patient is unique. So how often do you repeat the process? Do you train all new clinicians? Do you use regular chart audits? How do you keep adherence to guidelines up?

Susan Even, MD, University of Missouri, Columbia

In my experience – and there is some evidence – training doesn't work particularly well with physicians. The old expression is, "If you want it done right, give it to a nurse." So I do two things. First, I try to set up the system using our EMR, various clinical management reports, and CME for our clinicians to reinforce our commitment to evidence-based practice and guidelines. Second, I encourage our nurses to be involved in those cases where we have guidelines in place. Nurses do a superb job of ensuring outcomes on quality implementation are achieved. Lastly, this can't be a "retraining-every-six-months" kind of thing, it has to become the culture of the whole practice environment.

Allan Markus, MD, Arizona State University

No disagreement, but linking D.C.'s point about involving clinicians in the development of the guidelines and Allan's point about making it part of the culture, we discovered that by strict adherence to some guidelines, given the fact we are seeing a young mostly healthy population, we found we were overtreating in some situations. We involved our clinicians in revising the guidelines to better suit our population.

Polly Wheat, MD, Columbia University Medical Center

Being a nurse, I loved Allan's observation that nurses will follow guidelines, but realistically, building guidelines into the whole practice environment is critical. By this I mean "smart text" in the EHR, CME, and case conferences. Let's face it, there will be resistance to guidelines, and particularly if you are operating in a decentralized environment, you'll quickly lose compliance if it's not part of the culture.

Susan Quinn, MSN, APRN, Santa Rosa Junior College

A good example of making change part of the culture is the Depression Collaborative, an eight campus effort being led by my colleague Henry Chung. The Collaborative is a large scale change management effort designed to have all primary care initial visits screen for depression using the PHQ-9. Now in its second year, the Collaborative illustrates the value of linking individual interests with a broader vision. The key methodology is a short cycle PDSA (plan, do, study, act) approach where the culture among the participants from the eight schools is to share both what has worked and what has not.

Carlo Ciotoli, MD, New York University

In both the management of change and selling change up and down the organization, data and measurement are critical. More than ever the "data hounds" we work for demand the data to support our contentions.

Robert Wirag, HSD, University of Central Florida

Even with data, managing clinicians, in my experience, is more of a challenge. You are asking your clinicians to do a great deal – to screen for depression, tobacco, alcohol, STIs – and then to identify and respond to whatever complaint the patient presents. You, as a manager, must look at revisit rates as a sign that clinical staff may be "padding" their schedules or gaming the system with "no shows" and cancellations. What do you do?

Marcy Ferdscheider, MD, Columbia University

What management may describe as gaming the system, the staff may feel is their way to reach all the goals you set out for them. I think about our Health Center where there was an expectation to increase visits, increase number of unique patients seen, limit wait times for appointments, provide comprehensive screening and document the visits as comprehensively as possible. Then, if it turns out the staff is able to do that, but requires bringing some patients back for follow up visits, is that "gaming the sytem' or providing a solution to a problem management proposed? While I agree I could improve efficiency by perhaps 10% by addressing that particular scheduling issue, I risk losing exponentially the buy-in from the staff on all the other objectives we had strived to achieve. For me this is one of the biggest challenges, not always feeling the obligation to add my "two cents" which may improve a process somewhat, but again at the risk of buy-in from the teams working on the solutions.

Carlo Ciotoli, MD, New York University

Another good reason to schedule return visits for students is they need to keep hearing some of the health promotion, health education messages in small and frequently repeated bites.

Jan Palmer, MD West Virginia University

That is true, but there is plenty of evidence that some Web-based interventions can also be effective.

David McBride, MD, Boston University

I think you have to protect your clinical staff from being overwhelmed with additional tasks. My view is that we cannot volunteer to take on additional clinical duties, such as employee health, without additional resources. On the other hand, I am a great believer in perceived expertise. To be seen as an expert, you do have to volunteer for some visible assignments. I am happy to work on pandemic planning, for example, because I know that won't add any new clinical burden to my staff at least in the near-term.

Thomas Nary, MD, Boston College

Employee health may require additional resources, but it also can be scheduled to fit into slack times at the SHS. Our experience is that staff enjoy seeing a different patient population, and having employees who found the service they received was very good can be very useful "political capital".

Estelle Maartman-Moe, RN, University of Vermont

No disagreement, but most of us can't do everything we are asked to do. That imposes on us the obligation of pointing out what and where the trade-offs will be.

Lynette Mundey, MD, Howard University

But we also have to understand what the trade-offs will mean in terms of Return on Investment (R.O.I.). The current literature on the ROI on doing good health risk assessments on employees is between 1.5 and 5.7. The temptation is always to put direct patient care first and health promotion and disease prevention second. The data may not support those decisions.

Jim Grizzell, MBA, MA, CHES, HFI, FACHA
California Polytechnic State University

Change Driven by Facility Planning

The planning for our new building, which came out of the ground over a year ago, and which we will occupy for the 2008-09 academic year, precipitated many changes in our reporting relationship within the University, in the way we will be working in the new facility, and most importantly, in the student experience.

Starting with the student experience first, we chartered a small prop aircraft and took seven members of our SHAC to visit the SHS at the University of Georgia at Athens. From that trip onward, we had a growing group of articulate students who not only wrote a "manifesto" to the President about the need for a new facility, but also lobbied the community to get the final legislative approvals.

The planning for our facility also coincided with moving the SHS from a reporting relationship to the medical school to reporting to Student Affairs and, ultimately, to the Provost.

Because our location will be adjacent to the Medical Center, we will easily be able to have students get care and services in both settings.

Because the University is planning for staged growth through expansion of the freshman class over the next several years, we have built capacity for that growth into our building. We will be entirely electronic when we move in, with each clinician having a tablet to access the EHR and other systems. We will have embraced employee health, everything from respirator fit tests to state OSHA required physicals. These activities will generate modest margins.

We also will rent space to a pharmacy which will also have the usual retail offerings and to a food service where we will be able to influence a "healthy" menu.

An interesting part of this process is we are taking on full responsibility for our mortgage and our staff, some of whom have been with us for 20 or 30 years, is suddenly aware that we are self-supporting.

Gregory R. Moore, MD, MPH, University of Kentucky

Managing a Significant Change in Demand in Which the SHS Participated

Halfway through the 2005-06 academic year, and contemporaneous with Henry Chung assuming the position of SHS Director, we participated with Student Affairs and others in the University in a decision to substantially increase our health fee so that every NYU student would have no economic barrier to access a full line of primary care services at the SHS. Prior to this change, students who were covered by the University-sponsored insurance program had full access, but those who continued to be covered by parental plans were charged fee-for-service for much of the care received at the SHS. As a result, students on the University-sponsored plan used the SHS and students with parental coverage, in the main, did not.

By agreeing to this change, those of us managing the SHS anticipated a 25-35% increase in both unique student patients and in visits. And that is what happened, although closer to the 25% level.

In anticipating this precipitous growth in demand, we had to work on both physical plant capacity and clinical capacity. Candid discussions with clinical staff about these changes and our expectations for clinical workloads resulted about a third of our primary care clinicians leaving, some voluntarily, and some through "assisted attrition."

This was followed by aggressive recruiting. We looked closely at scheduling – which uses 20-, 30-, and 45-minute appointments – and modified those who had the ability to block appointments. We eliminated courtesy insurance filings and reduced our insurance reimbursement staff. With minor adjustments, we had adequate space for patient care.

Counseling, which had operated on an open access model without economic barriers, did not anticipate any significant growth and yet their experience quite closely tracked ours.

At the same time these changes in access were occurring, our Wellness Exchange service was entering its second year – a 24/7 telephone hotline staffed by our social workers from 9 a.m. - 9 p.m. and by a contract agency with specific protocols and an on-call staff from our program who can quickly get to a student in acute distress in any residence hall.

Added to that was our depression screening, which I already described.

The bottom line is that we put a very significant demand on our staff to respond to a very large change and they did a terrific job. Lessons: it was critical to tell them the vision and be sure they understood the importance and validity of what we were doing. Second, as I said earlier, I have tried to resist the notion that staff may be "gaming" the system with revisits, etc. We think you should assume good intentions and wait before you act in managing large-scale change.

Carlo Ciotoli, MD, New York University

Your comments about the increases in demand at the counseling center, the work of the Wellness Exchange which must also add to demand for behavioral health, and your depression screening, how do you find the clinical resources to deal with all of this?

Leigh White, MD, Michigan State University

There is actually a fourth factor, a new law in New York on mental health parity. Here is how we handle it. We have a psychiatric nurse practitioner in the SHS and Henry is also a psychiatrist. We have a unified medical record with counseling (although we don't see psychotherapy progress notes) and we have four psychiatrists in CAPS.

For providers in the community, we have had a particular challenge in finding people who would treat students at a reasonable fee. Henry has contacts with some community clinics and Chickering has worked hard to find and credential additional providers. I'd say we're okay at this point.

Carlo Ciotoli, MD, New York University

Just to follow-up, with our population at West Virginia, we have a number of students who are uninsured. We have virtually no access to psychiatrists in the community. We transfer perhaps 90% of our behavioral health to primary care, but we can't deal with dual diagnoses, bipolar disease and acute personality or thought disorders.

We have 4.5 FTE psychiatrists for 27,000 students and they can only deal with assessment and medication management.

Jan Palmer, MD West Virginia University

Spectrum: Let's then open this issue up to those changes required by the increase in demand for behavioral health services.

Behavioral Health Demand

The current generation of students has more psychiatric diagnoses, more serious diagnoses, and is being prescribed more psychotropic drugs. This increased demand is not only taxing Student Health and counseling services, but also our disabilities services, which have to be both more sophisticated and more resourceful in the post-Katrina environment.

We are responding to this increased demand by trying to hire more psychiatrists, psychologists, psychometricians and social workers. Our mental health service is fully integrated into Student Health, but adding staff will require we find new space which will be separate.

One of the contributing factors is that, post-Katrina, we have accepted more transfer students from two-year colleges. My sense is that these students have many more behavioral health issues. The increase in demand from traditional freshmen has not been as great.

James A.H. Farrow, MD, Tulane University

Not only are we seeing a similar increase in demand, we are also seeing a much higher degree of direct involvement from the "Millennial-generation" parents to be sure we are caring for their child. Many want to be highly involved in their child's care, especially for mental health services.

Allan Markus, MD, Arizona State University

Parents are certainly a significant issue. At orientation we are far more likely to see a parent than the student, with many students providing parents with release forms for medical information, including psychiatric care and counseling. Another challenge with parents is explaining our brief treatment approach in mental health.

James A.H. Farrow, MD, Tulane University

We are now seeing 20% of all of our students for behavioral health issues – an increase of about 15% from last year. The increase in number of students has been compounded by a new state law in New York (Timothy's Law), requiring equal benefits for behavioral health and medical conditions. To help put some limit on this, we changed our benefit for illness and accident from unlimited to sixty visits. Of course sixty visits for counseling or therapy is far from the brief therapy model, but we felt it was a reasonable outside limit. At Columbia Health Sciences, we have long felt the need to support the psychological and emotional needs of our students who have some unique transitional issues.

We have used the NCHA survey to look at barriers to academic success. Five of the top six "barriers" listed by our students were behavioral health (the other being URIs).

Polly Wheat, MD, Columbia University Medical Center

I can tell you it is a similar story at MSU. Managing behavioral health demand may be our biggest current challenge.

Leigh White, MD, Michigan State University

Going back to Jim's comment about Tulane's two-year transfer students having more behavioral health issues, that is certainly consistent with my experience. Last spring, 13 community colleges completed the NCHA survey, which confirmed Jim's observation.

So what do we do with the student who writes an essay which alarms the faculty with its content? Unfortunately, the best most community colleges can do is use psychology graduate student interns and try to find other appropriate resources in the community. Since many of our students are uninsured, we have the dual problem of more need and less access.

Susan Quinn, MSN, APRN, Santa Rosa Junior College

Not only are we seeing more behavioral health issues, but also cases that are more complex to manage in the context of student life, academic life, and accommodations. In the last year or so we have had one student with Asperger's syndrome. This year we have seven, and most don't want help from disability services. This is just one example of the increase in demand for services from students who, in the past, did not usually enter the higher education system.

Kathy Hunter, CRNP, FNP, University of the Pacific

In addition to our growing demand for behavioral health services from our traditional four-year students, we are now planning for returning veterans. I am part of a task force to recommend programs and services which will anticipate the unique needs of veterans. Part of that challenge is the University's historic reluctance to accept transfer credits for community college work. While not a Student Health problem per se, if Jim and Susan's observations are correct about a higher incidence of behavioral health concerns among community college students, added to all of the issues facing returning veterans, we are likely to have a significant demand problem to address.

Susan Even, MD, University of Missouri, Columbia

"[Regarding the changing culture of our students...[at Cal,] more students have Asian American. Fifty percent are from homes where English is not the primary

We too are working on what will be required to have veterans at University of Massachusetts. We know that many will have psychological issues, family tensions and financial concerns without having post-traumatic stress disorder. We are developing a triage system for behavioral health – not just for veterans – to determine what we can do on-site and what we will have to refer out. Like others have said, we are also seeing more parental involvement. It is not uncommon for the parents of a 26- or 28-year-old to want to be involved in their child's care.

Kathleen Golden McAndrew, MSN, ANP
University of Massachusetts, Boston

What are the rest of you doing about recruiting additional behavioral health staff? Our CAPS is separate and has been very challenged in recruiting, perhaps because of our location. We have recently taken on three

Student Health Insurance: Outlook

Stephen Caulfield, MSW and Dale Grenolds, The Chickering Group

The participants at this year's Leadership Forum raised a series of questions about environmental changes, including the outlook for student health insurance in the context of the 2008 elections and possible changes in health policy at the national level.

Public Policy, Employer-Sponsored Plans, and Student Coverage

If one looks at the positions of the candidates, as well as trends in employer-sponsored plans and Medicare and Medicaid, it is likely there will be a bi-partisan effort to expand access and to reduce the rate of increase in per capita health expenditures. While the financing mechanisms for these efforts will depend on the political process, it is virtually certain that the changes will be both incremental and based on a public/private partnership. Two significant trends will frustrate these efforts: the aging of the population and the withdrawal from the market of employers, either through lower contributions to coverage, or through eliminating certain dependent groups from eligibility.

From the view point of student health, it is likely that some employers will withdraw from coverage of some college-age students, even while states enact laws permitting coverage to higher age limits. This will be done by reducing premium subsidies for dependents, the growth in consumer-driven health plans with high deductibles, or dropping coverage altogether. Employer and individual mandates, of course, could reverse these trends, but those are unlikely to be significant over the next two to three years, and when they are enacted, they are likely to be on a state by-state basis, and not a federal mandate.

This will leave higher education with an increasing number of students who will enroll with either no insurance or less than adequate coverage, arguing strongly for hard-waiver programs which are specific both with regard to coverage levels, and the ability to use providers both proximate to the campus, and more broadly as students travel both domestically and internationally.

Student Health Insurance Cost Components

The costs for student health insurance will depend on changes in five areas:

- Pricing,
- Utilization,
- The mix of services, procedures, and pharmaceuticals used by students,
- Changes in the disease burden of incoming freshmen (perceived and/or real), and
- Public policy, principally cost shifting from Medicare and Medicaid and mandates such as mental health parity, or the recent changes in the ability of Student Health Centers to purchase oral contraceptives at favorable prices.

Because student health insurance is heavily driven by payments to physicians and other outpatient providers, student health insurance pricing trends will be closely linked and particularly sensitive to changes in physician reimbursement by Medicare, which could result in unfavorable cost shifting to private payers.

iPods than have health insurance. Sixty percent of the students at Cal are language." – Ronald Elson, MD, University of California, Berkeley

psychology interns who have been a great addition, but as we are now staffed, all we can do is brief therapy with acute conditions.

Kathy Hunter, CRNP, FNP
University of the Pacific

What are your ratios of behavioral health staff to students?

Hugh Jessop, PhD, Indiana University

Ours are about 1:2,000 with almost all of our psychiatrists in the Student Health Services, while CAPS is predominantly psychologists. The demand from students in our professional schools is somewhat higher than our undergraduate population. Like most of you, we use a brief therapy model for most patients, but can accommodate a small number of longer term therapy patients, and a greater number of medication management patients.

D.C. Dugdale, MD, University of Washington, Seattle

COMMENTARY

The second cost factor, utilization, is closely tied to access, both economic and physical. It is well documented that locations with higher concentrations of hospital beds have higher rates of admissions, the more specialists in an area the more specialty care, etc. Where students have had pre-paid primary care available through the Student Health Service, and particularly where the Student Health Service has been able to offer some frequently used specialty care on campus, we have observed a moderating effect on the utilization of the student health insurance. Directing access to insured services, including referral requirements seem to work best when they create opportunities for the Student Health Service to offer a primary care assessment prior to a referral. The rate of increase in utilization among college and university students is highest for behavioral and mental health services, and seems to be moderating slightly for other services, although the general observation holds that students are using more care each year. Obviously, increases in the underlying morbidity of the population will directly influence utilization, but improvements in health literacy and knowledge about when it is appropriate to access health care could work to reduce unnecessary and inappropriate utilization.

The third cost factor, the changes in the mix of services used by students, will be influenced by replacement technologies (such as imaging), alternative loci of care (outpatient surgery), changes in pharmaceuticals (new drugs, off-label utilization and generic replacement), alternative medicine (acupuncture, message), and, most critically, the degree to which Student Health Services will expand their treatment portfolios to include some of the services formerly purchased in the community. Payment to the Student Health Service for these expanded treatment offerings could be included in an expanded health fee, capitation from the university-sponsored student health insurance plan, or fee for service.

The fourth cost factor will be the change in the underlying disease burden of each entering freshman class. College health has observed an increase in the demand for behavioral and mental health services over the past five or six years that has increased 50 to 60% over this period. Students with significant chronic and recurring conditions are now being admitted to colleges and universities in increasing numbers, requiring some additional accommodation and student health resources. Broad-based cultural expectations about health and health care can also contribute to demand, either dampening or exacerbating students' (and their parents') reliance on student health services and student health insurance.

The fifth factor will be public policy at both the state and federal levels. Mental health parity is a good example, but there are others such as immunization requirements which can directly and immediately increase costs. Employer and individual mandates to purchase insurance are likely to occur both more slowly and on a state-by-state basis.

However these five factors play out, one can be sure that student health insurance will experience different cost

Continued on page 16

"Another significant "external" environmental change we are dealing with is a which is probably reflective of the growing conservatism of the community...Our value system to make those choices which have a "moral" value." – SUSAN EVEN, MD,

As an alternative to adding staff, we have introduced a Student Assistance Program (SAP) modeled after an Employee Assistance Program (EAP), provided by an outside vendor. I reported on this in *JACH* [*Journal of American College Health*] about a year ago. The program is in its third year. It's funded by a $20 fee per student per year. For that fee, students get telephone access 24/7 and up to six visits at no cost with a national network of counselors, all of whom have been credentialed. The six visits are for a specific issue, so if a student has a second "issue" they are entitled to another six visits. The telephone service is also staffed by professional and credentialed counselors.

Because we are a health sciences campus, our students are concerned about behavioral health issues being on their medical record. They are also concerned about being treated by members of the faculty. The SAP is seen as "off-campus" and therefore a more confidential and appropriate resource for some students.

The SAP certainly has helped manage many of the needs for support and advice for some of our students, but it has not eliminated all of the increased demand we

Student Health Insurance *(continued)*

pressures than either employer-sponsored plans or Medicare or Medicaid for two powerful reasons: the unique demographics of the college age population and the year-to-year changes in that group, resulting in a different market basket of services used by students: and, second, the presence of Student Health Services on most campuses, which provide direct access to primary care and health promotion and health education.

An open question is the degree to which strategies for disease management can be effectively employed in this population. The early indications from Dr Chung's Depression Management Collaborative are that disease management for depression can achieve increased adherence to the appropriate psychopharmacology and psychotherapy. In this example, it is unlikely that disease management will result in any reduction of direct health care expenditures, although it is possible that there may be a reduction in somatic complaints from the depressed student who is adhering to appropriate treatment. In fact, some suggest that in the case of depression, disease management may increase costs, at least in the short term.

Can colleges and universities influence these factors so that the costs of health care for students and student health insurance moderates over time? We think so. Two interventions are known to have positive effects on student health insurance costs: expanding the risk pool as broadly as possible through rigorous hard-waiver programs (or more ideally, mandatory programs where all students are in the same risk pool); and expanding both access to, and the capacity of, the Student Health Service to include some specialty care that would normally be rendered in the community. A third, more marginal, but important student health initiative is prescription drug management through formularies, drug utilization review (DUR), and treatment guidelines for frequently occurring complaints such as UTIs, sore throats, and URIs to reduce the inappropriate use of antibiotics and excessive use of lab tests.

Given these multiple variables, what is the outlook for the cost trend in student health insurance over the next two to three years? Because students appear to be early "adopters" of new technologies in health care and in other parts of their lives, and their physicians often order and prescribe from the most current treatment alternatives, upward cost pressure from replacement technologies and pharmaceuticals is likely to continue. As noted above, this pressure could be moderated by actions within the Student Health Service.

The Outlook for Student Health Insurance Costs

The cost pressures on outpatient physician services will be most strongly influenced by the practice settings, with costs increasing as more physicians leave individual and small group practices for larger organized systems of care, which carry higher overhead costs. The cost shifting dynamic from public sector programs to private payers will continue, *growing conservatism among our Curators (Trustees) and politicians, position is to empower our students and patients to look to their own*

University of Missouri, columbia

have in Student Health. We have recently hired a 60% time psychiatrist in Student Health which should help.

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

We too, are a health sciences campus, and because we understand the stresses associated with our programs we have established a new committee – "Students at Risk Committee." Our objective is both to increase the student safety net and also to alert all faculties to the signs and symptoms of students in distress. We now have a video online for faculty, and our hope is that it will become part of CME.

Polly Wheat, MD, Columbia University Medical Center

We have a similar committee which is interdisciplinary, including Law Enforcement, Academic Affairs, Judicial Affairs and Student Affairs.

Kathleen Golden McAndrew, MSN, ANP
University of Massachusetts, Boston

Like Peggy, we have an outsourced 24-hour

but the degree will depend on the actions of Congress to protect physicians from cuts in Medicare reimbursement. Our bottom line: our costs for physicians' services will continue to increase at rates greater than either GDP or CPI, how much greater being unknowable.

Prescription drug costs for the insured student population will behave somewhat differently for several reasons. Among the benefits offered in student health insurance plans, the prescriptions drug benefit is the easiest for the student to do a cost benefit analysis for, if they are on any long-term drug therapies. Thus, the insurance is virtually guaranteed to get higher levels of adverse selection on the prescription drug benefit than any other component of the plan. Second, many student health insurance plan designs limit the prescription drug benefit. How these limits are set will change the magnitude of any change in utilization and price. Third, for some years we have observed a triple multiplier effect in prescription drug benefit plans: first more students in the population are filling prescriptions; second, for each student who uses the plan there are more prescriptions; and third, our average cost per prescription has increased. Under the rule that "trees don't reach the sky," we would expect some moderation in observed drug trend, but we believe it will still increase at low double digit rates.

While we anticipate that, over time, the states will work toward solutions for the uninsured, the challenges in getting SCHIP passed suggests this process will not be easy, and there will still be large numbers of college student who are uninsured or underinsured.

Opportunities to Moderate Student Health Cost Trends

Regarding efforts to moderate the costs of student health insurance, it would seem that the two large levers are in the hands of the colleges and universities themselves: first, adoption of hard waiver policies and mandatory insurance requirements for specific at-risk groups such as international students, and, second, expansion of the capacity and funding for Student Health Services.

So our conclusions are that public policy over the next few years may somewhat ameliorate the uninsured problem, but those improvements will not significantly alter the number of college students who are uninsured or underinsured, and trends in employer-sponsored plans could exacerbate the problem for colleges and universities. We also feel that the interplay among the five cost factors discussed above will net out to cost trends for student health insurance running significantly higher than CPI and GDP and will likely run higher than tuition increases. Colleges and universities can reduce these cost pressures by expanding the risk pool through hard waiver programs, and expanding access to Student Health Services. Campus-based programs to improve health literacy can also be very helpful in promoting appropriate utilization.

emergency phone service vendor, EMPACT, which has both a suicide prevention and sexual assault hotline, which students can contact either locally, statewide or nationally. My question is: how do we measure outcomes for behavioral health and health promotion activities, whether they are outsourced or part of our program? This evaluation question may be more challenging in those programs where CAPS and Student Health are separate and where Student Health is working within a culture of evidence-based practice.

Allan Markus, MD, Arizona State University

We had used the NCHA data prior to starting our SAP. We will repeat it and, thus, have some "pre" and "post" data, although we are well aware that there will be different students responding. Our students have also developed their own stress survey which has been administered three successive years now that we hope will contribute to our evaluation process.

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

I want to echo Allan's call for evaluation of these efforts. They are consuming (or at least requiring) more resources, which requires justification. I know the ACHA benchmarking committee has considered the idea of including mental health in its future work. Data such as this would undoubtedly help.

Bill Purdy, MD, Duke University

We measure retention, where people seek care and all of the relevant NCHA questions on risk behavior, stress, and factors detrimental to academic performance.

Kathleen Golden McAndrew, MSN, ANP
University of Massachusetts, Boston

All of that is good, but I think we have to track something other than negative outcomes. At Tulane, when a student becomes known to Student Affairs, he or she is assigned a case manager in the hope that that person can help the student stay in school and perform up to their potential. Despite this case management process for students who are thought to be at risk, we still have a number of students who withdraw for behavioral health reasons.

James A.H. Farrow, MD, Tulane University

Retention is the far end of the student success/academic achievement spectrum, i.e., academic mortality. We also try to look at "academic morbidity" – that is, sub-optimal academic performance (i.e., missed classes, lower grade point averages, transfer to less demanding majors).

Ferdinand Schlapper, MS, Boise State University

Medical Withdrawals

Many participants described multidisciplinary teams that review medical withdrawals. Dr. Elson's description of the Berkeley process is quite representative of the process at other universities.

Our multidisciplinary Withdrawal Committee is chaired by a social worker, an appropriate choice because of her knowledge of both campus and community resources which might help the student continue in school. Over time, the committee process has become more formalized (with help from University counsel). Our "semester out" rules are supportive and not punitive, and are helpful in terms of fairness and equity.

Ronald Elson, MD, University of California, Berkeley

Resources for Behavioral Health

Other than the SAP and those who report some new hires of psychiatrists and other mental health professionals, what do you do if you don't have access to additional resources?

Susan Even, MD, University of Missouri, Columbia

One approach to stretching limited resources is the use of groups. Unfortunately, I can't report much success with groups at Berkeley. Like most of you, we have had an increase in the number of students presenting with mental health problems, as well as seeing an increase in the severity of those problems.

In an effort to be more effective with our limited resources, we started several core support groups – a bi-polar group, for example. What became clear quite quickly was that our students were reluctant to use groups and participation in all of them dropped way off. We have not studied why our students have chosen not to stay with the groups they were offered.

What really caught our attention regarding the severity of the symptoms our students are manifesting were 100 admissions in the past year. These admissions may be linked to students not receiving the appropriate psychotropic medications, and/or their failure to adhere to the prescribed therapeutic regimen. This, in turn, may be linked to our concern about the adequacy of our prescription drug benefit, which has a $2,000 limit. We also are no longer permitted to use samples, which raises questions about whether students are filling prescriptions and are persistent in taking them as prescribed.

Ron Elson, MD, University of California, Berkeley

We have found that the combination of purchasing through a consortium, centralizing all of our samples in our pharmacy, and having a prescription assistance program – all of which is done by our pharmacy staff – seems to meet most of the needs of our students.

Allan Markus, MD, Arizona State University

We have a similar program where our Hospital pharmacy keeps all samples and we may write prescriptions for samples for the students who do not have adequate coverage. Since we still have some students in the lower-cost plan of our two-tiered insurance plan, those students are eligible for prescription assistance. In addition, our patient service representatives assist students in completing the complicated application process required to request assistance from pharmaceutical companies.

Susan Even, MD, University of Missouri, Columbia

The cost of a pharmacy assistance program can vary depending on the volume. In my previous position in a smaller clinic than our current University clinic, we managed the prescription assistance program with one pharmacy technician, but the cost benefit is huge, in millions of dollars of medications.

Allan Markus, MD, Arizona State University

We have a similar program, utilizing one registered medical assistant and our total savings just crossed one million dollars. Our students express their overwhelming appreciation for this support service, recognizing their critical need for prescription medications, the high costs of many of those drugs and the limited coverage provided by their health insurance plans.

Ferd Schlapper, MS, Boise State University

There is no question that pharmacy assistance programs are important, but it is worth noting that some drug companies are very helpful, while others are not. The prescribing physician may not be aware of those differences and may not have an alternative drug they feel is appropriate.

Polly Wheat, MD, Columbia University Medical Center

While not specifically on the issue of pharmacy assistance, but on the larger point of time-consuming patients and conserving resources, we have recently decided not to take on new patients for the treatment of ADHD because of the complexity of the required work up and the risks of prescribing stimulants on a college campus. We have found that ADHD students and their parents seem to be able to manage both the work up and the prescription drugs outside of Student Health. We are quite comfortable with this decision because it is generally agreed that the work up, treatment and follow up for ADHD patients are out of the scope of our primary care mission in Student Health.

Mary Rae, MD, Texas Christian University

In terms of having to prioritize our activities because of limited resources, Student Health in community colleges is probably at the far end of the spectrum, relying heavily on both other campus resources and community services. We have a crisis and case management team that involves academic counseling, disability resources, police and Student Health. This team both deals with students who are manifesting significant functioning difficulties, and with the training of the faculty and staff so that they may identify students who are getting into difficulty early. This team is also the group that works directly with the administration, recommending what students may need to be withdrawn, for administrative reasons.

Susan Quinn, MSN, APRN, Santa Rosa Junior College

Going back to Ron's comment about the challenge of using groups, we, too, have been unsuccessful for years in using groups, but we keep trying. More and more of our students are living close to campus, so we thought the convenience would attract them, but thus far, these counseling groups have not worked for us. However, we have had some success with our "Lunch and Learn" program, which covers a variety of topics, some of which are psycho-educational and some of which are health education and basic health literacy. These are quite successful, much more so than our counseling groups.

Kathleen Golden McAndrew, MSN, ANP
University of Massachusetts, Boston

We have had some success with groups, in part because there is a long waiting list for individual counseling.

D.C. Dugdale, MD, University of Washington, Seattle

Our CAPS and our SHS are separate, with our Health Center housing psychiatrists and psychologists. Our Student Health psychologists offer groups, which use a psycho-educational model, not interactive, for things like anxiety, where participants are taught techniques of mindfulness and stress reduction. The cost to the student is modest, but still only eight or ten students participate. CAPS offers some interactive groups which are also hard to fill.

Susan Even, MD, University of Missouri, Columbia

Thinking back to my days at Barnard, the only group we had any success with was a bereavement group.

Polly Wheat, MD, Columbia University Medical Center

In a similar model, we have started a group for students who have lost relatives overseas, in Iraq and Afghanistan. That group seems to be working.

Kathy Hunter, CRNP, FNP, University of the Pacific

In thinking about what changes we will have to make to accommodate the increasing demand for behavioral health services, integration is not one of them. Our CAPS and Student Health have been integrated for 25 years. If we tried to separate them now we'd be killed. We do maintain separate EHRs, although if the student is on medication, that information is linked to the SHS EHR. Our problem, like most everyone else, is purely professional resources. We can gain nothing by reorganizing, we need people. My plan is to reconfigure space in our counseling service this summer, and then seek additional staff. I am collecting data now on our inability to meet all of the requests for behavioral health services. In making a request for additional people, you should have three things:

- The data that shows existing resources are prudently deployed and are working at capacity,
- The data on unmet demand, and,
- The staffing ratios that are recommended, or, if better, the staffing ratios at peer schools (which is why I asked the question earlier).

While I agree with Allan's call for outcome measurements, for the time being we have to make our resource pleas on data we can put our hands on today.

Hugh Jessop, PhD, Indiana University

We think it is important and efficient to have a holistic model integrating counseling and Student Health. Key to this are primary care practitioners who can pick up signs and symptoms, handle many appropriately, and refer the more complex cases. Having said that, we too are stretched thin.

Despite being stretched thin, I am struck by the strong thought that we are on the verge of a dramatic and dynamic reframing of our counseling service's role and scope of support. Comprehensive and holistic integration with health service professionals, student affairs colleagues, faculty, parents, and campus leadership has never seemed more critical.

Ferd Schlapper, MS, Boise State University

Many participants commented on the question of whether the integration of CAPS and Student Health added efficiency through more balanced resource allocation and shared case management. While there seemed some consensus that this was the preferred model, several participants pointed out that the academic politics could be daunting. The different reporting lines, for example, CAPS to Student Affairs and Student Health to the academic medical center can complicate the process of approvals for additional resources, the adoption of a standard EHR, and integrated training and continuing education. Others noted different funding models, and others, different missions, with counseling having a teaching and training mission for psychologists, with the care of students secondary to training and education.

What was clear was that the virtually universal increase in demand for mental health services was going to precipitate change in Student Health programs as they struggled to find new resources, improve efficiencies, reduce the demand, or alter expectations for what college health and counseling can reasonably be expected to provide. The mixed experience in the use of groups, the use of interns, nurse clinicians, community agencies and primary care providers are all indicative of thoughtful and somewhat successful efforts to serve this increased demand, but the consensus remained that demand was still substantially greater than available resources. So what to do?

I think we have to take a much broader, population-based approach to providing our students with both the skills and the appropriate expectations about what is, and how does one achieve, long-term well-being in the culture in which one lives. You are starting to see courses at places like Harvard and Berkeley on things like ‘the science and practice of achieving happiness and meaning.’ Students are moving from adolescence to adulthood, which carries with it much stress and discomfort. Students need to understand that that goes with the territory, but they also need to learn how to deal with it.

I think we can do more to prepare the whole student body for living with stress and finding some joy and happiness during their higher education years and beyond. We’re in the process of developing a course on achieving happiness and well being, which would carry full academic credit.

Ira Friedman, MD, Stanford University

The Implementation of an EHR as a “Change” Event

Our implementation of an EHR was a more significant change event than we had anticipated. We felt we had been careful to involve our clinical staff in the selection of new practice management software which incurred the EHR. We thought we had done adequate training.

Prior to implementing the EHR all of our physicians used dictation, and one or two used it excessively. Were we doing this again, I would shut off the dictation at least a month in advance of implementing the EHR to get people used to writing succinct clinical notes.

Well into our implementation we brought in practicing physicians who had been using the system for some time. Not only were they great advocates, but they showed as certain “tricks” and shortcuts. I don’t know at what point doing this is best. Too early in the process these testimonies might not be credible. On reflection, I would have done this sooner.

Of course the major resistance was it is difficult to capture the nuances of complex complaints.

Some clinical staff left rather than adopt the EHR. Without exception, these people grew up in a more autocratic period where physicians ruled (or thought they did). Initially, physicians saw fewer patients, while overall visits went down. Prescriptions and pharmacy use dropped, but it is probably too soon to say these changes will hold up over time.

It underscored something we know; nurses were more flexible than physicians.

James R. Guest, MD, University of Nebraska, Lincoln

To get around the resistance about EHRs’ limitations on narrative clinical notes, we started our implementation with our psychiatrists. When they became converts, it was much more difficult for our primary care staff to claim that it was impossible to capture primary care visits via a templated note.

Gregory R. Moore, MD, MPH, University of Kentucky

We also noticed it built a bond with students who both liked the technology and liked helping our docs use it.

James R. Guest, MD, University of Nebraska, Lincoln

Our EHR allows clinicians to free text their notes. Since all of my physicians have good keyboard skills, they found the transition to the electronic record fairly painless. On the other hand, our nurse practitioners prefer using the templates.

Nell Davidson, MD, Case Western Reserve University

A New Director with a Change Mandate

A little more than a year ago I assumed responsibility for the Student Health Service at Boston University. The SHS is located on the Charles River Campus with 28,000 students, 14,000 of whom live in campus housing. A mile away is the Health Science Campus with about 4,000 students. The medical students are insured through a local managed care company. The School of Public Health and the Charles River have a plan through Chickering.

The SHS and its staff had taken care of students without any significant change for many years, including an infirmary which often has been used for students with some level of behavioral health crisis.

There were 20-25,000 visits per year and very little sense of an obligation to the public health of the campus.

I was hired by the Chief of Family Medicine where I had been on the faculty and the VP for Administration. I had previously been a primary care physician in another Student Health Service in Boston, so I was not a stranger to student health.

My mandate was clear, if not specific: "preserve what is good and appropriate, eliminate what is not, add what is needed."

There were obviously some very easy decisions, for example to close the infirmary, which yielded new clinical space and freed up some very good people. There were also some easy people decisions, many made by the people themselves to retire or leave without any intervention from me.

The more challenging personnel decisions I tried to make early, fairly, and with as much grace as one can.

The Chief of Family Medicine had a vision for Student Health, but no specific plan. I felt I had to move quickly to get to a core staff that I thought could help me figure out a plan for that vision. I needed to be able to say, "Everyone who wants to be part of this has a job at far as I'm concerned. It just may not be the job you currently have."

In addition to closing the infirmary, eliminating some positions, we've focused in the past year on how to do a better job taking care of those students who show up. We are an all walk-in service, so you know we're very busy Mondays and Tuesdays.

We have no separate CAPS, but our behavioral health is multidisciplinary – psychiatrists, psychologists, social workers and clinical nurse specialists.

David McBride, MD, Boston University

What are your reference points and support systems as you make these changes?

Jan Palmer, MD West Virginia University

I have visited with my colleagues in Student Health in the Boston area and in New York. I continue to have great support from both Family Medicine and University Administration. I have allies on staff who have been there a long while and enjoy the energy of rethinking how best to serve students. And I have a few new hires.

We have some union employees, but that has not presented any significant problems.

An ongoing challenge, and one where I could use your help, is how to deal with employees who are not as motivated to change and grow.

David McBride, MD, Boston University

I think there is only one answer: performance management with consistent and repeated messages about what is expected. Careful and honest performance appraisals with as much quantitative data as possible, and good coaching about how to improve.

Estelle Maartman-Moe, RN, University of Vermont

I agree, but you also have to be sure the individual reads and understands the performance appraisal. Sometimes you have to go through it point-by-point. One thing I add to Estelle's list is a clear timeline for expected improvement. And if none of that works, is there a different position which would play to that person's strengths?

Lynette Mundey, MD, Howard University

David's question raises the larger question on managing down, not just the issue of one individual's competence, but the whole question of organizational inertia.

Let me give you an example. When I arrived at Columbia about two years ago, the SHS had been a client of Point 'N Click for about five years. I think they were the third client. They were only using the practice management software until Samuel came and made the project a priority. I was able to assist in that effort because I had had experience with the program and was able to act as a "superuser." I was very up front about expectations about use of the clinical portion of the electronic chart and basically just started turning on applications and training the staff how to utilize them.

Our expectation is that primary care physicians carry a panel of about 1,500 students compared to the usual MGMA (Medical Group Management Association) panel of 2,300-2,500. Of course, in college health, being assigned a panel does not mean those students will always see you. We also have a physician who only does urgent care, works from 11 a.m. to 7 p.m., and sees 25 patients on a busy day. By doing this, we increased the availability of our primary care providers and gave the students the access to primary care that they needed which allowed us to further our continuity model.

What the care management software provides us are close to real-time data about how we are using resources, which permits us to rebalance between primary care and urgent care based on these data.

Marcy Ferdschneider, MD, Columbia University

Your comment about panels and the fact that students favor convenience over continuity of care is borne out in the utilization of our Quick Clinic, which has been unbelievably successful. We're coming to the realization that most students will choose convenience over continuity for minor and acute problems. That's why we continue our urgent care clinic and why we started our Gopher Quick Clinic. However, for chronic, recurrent, and more serious issues, students still want a good primary care experience.

Ed Ehlinger, MD, MSPH, University of Minnesota

I agree with Ed that students favor convenience over continuity. It's the responsibility of the clinician to review the record looking for patterns that might suggest a diagnosis is being missed (like an eating disorder, etc.). The clinician's motivation to do this is "pride of ownership" – that the standard of their clinical work reflects on them as physicians and they care about this deeply. It is the clinician who must ask, "What's really going on?" with the woman who asks for four pregnancy tests in the course of a semester.

Nell Davidson, MD, Case Western Reserve University

Process Mapping and that "Lean Thinking" Approach to Changes

Arriving at Bowling Green four years ago, it was clear there were several opportunities to improve our ability to serve our students. Several were linked to improving our information systems, including practice management and an EHR, and more efficient billing for services covered by insurance.

But, as we all know, change is difficult for many people and over the past four years about a third of our staff of sixty have turned over.

Over a year ago, convinced we now had all the right people on board, we began to think about applying "lean" processes to what we do. The key principle in the lean approach is to engage and respect everyone's contribution in a systematic review of how we work.

We created four "lean teams" which involved staff from all disciplines to look at pharmacy and lab, examination room utilization and provider flow, business and information systems, and patient and information flow. These teams have changed the tone of our work to be much more positive. The idea is to examine every step of our current processes to see both how they meet our customers' needs and ensure quality. From that we see things we should stop doing because they don't add value and things we need to do to make the process more efficient.

The work of these four teams overlaps so that we have the groups work together to be sure all recommendations are aligned. We are not through, although we have made significant progress in making most of our systems and procedure more efficient.

Nell mentioned "pride of ownership". That is perhaps the biggest benefit we have seen in the LEAN process.

Glenn Egelman, MD, Bowling Green State University

The Changing Environment of Student Health

Let's talk a bit about the changing environment in which we are working. Let's throw into that the changes in health costs – particularly health insurance, which is growing much faster than tuition and fees and which is projected to continue to grow faster than GDP. Let's also talk about the uninsured student and what we do with student aid in a hard-waiver plan. And, let's talk about the costs within Student Health rising faster than tuition and the limit on our health fees. What are the chances we'll see health insurance rates stabilize and our own SHS budgets get adequately funded?

Polly Wheat, MD, Columbia University Medical Center

Let me add to Polly's list the changing culture of our students. She mentions the uninsured…more students have iPods than have health insurance. Sixty percent of the students at Cal are Asian American. Fifty percent are from homes where English is not the primary language.

Ronald Elson, MD, University of California, Berkeley

In the community college system, we not only have first generation students like Ron describes, but we also have many undocumented aliens. They stay away from Student Health and community health because of a fear of being deported. Our strategy is to try to reach them through ESL classes. In fact, we use ESL to do a lot of our health education and health literacy work. If they are going to learn to read and write English, they might as well be reading and writing content that will be helpful to them. So we work with the ESL program to provide content on everything from STIs to prenatal care.

Susan Quinn, MSN, APRN, Santa Rosa Junior College

Another significant "external" environmental change we are dealing with is a growing conservatism among our Curators (Trustees) and politicians, which is probably reflective of the growing conservatism of the community. Issues like "safe sex" and "safe drinking" are now being questioned, with abstinence being the frequently suggested appropriate behavior. Our position is to empower our students and patients to look to their own value system to make those choices which have a "moral" value.

Susan Even, MD, University of Missouri, Columbia

On our campus our nationally known health educator recently tried to roll out a campaign called "Party Safe". She was told she should not use the word "Party" in the campaign. So the environmental conservatism of which Susan speaks is not limited to Missouri.

Allan Markus, MD, Arizona State University

Susan's point about working with students to make them comfortable while making their own moral value choices is what we try to do. Unfortunately, some try to dictate what we should do for everyone, for example, about 10% of our students feel we should not distribute birth control.

Kathleen Golden McAndrew, MSN, ANP
University of Massachusetts, Boston

I think the key to dealing with anything that is potentially controversial is to keep your administration informed every step of the way. Work with them pro-actively so that everyone is on the same page and there are never any surprises. Who is our target audience? What is the ultimate objective? How is it developmentally appropriate? What are the researched-based best practices? You will undoubtedly have concerns raised by various constituents, however, the University leadership will be well-prepared to respond to those concerns.

Ferd Schlapper, MS, Boise State University

While it may be somewhat tangential to these larger environmental issues, I'd like to mention outsourcing in the context of a smaller urban campus like ours. I realize that most of you are from larger schools and have limited your outsourcing to discrete parts of your program like your SAP. It may be worthwhile in this discussion about the changes in the external environment to describe our SHS, which we have totally outsourced to a local hospital, St Mary's, which is adjacent to our urban campus here in San Francisco. For a capitation fee of less than $100 per student per year we get urgent care for our students. By outsourcing, the moral values question is not ours, but the hospital's, although we are both Catholic institutions. We do have to revisit our contract to look at appropriate performance measures. Certainly things like wait times and patient satisfaction could be included, but I doubt we would try to get into whether they were using the appropriate clinical guidelines. For an institution like ours, when you analyze the "make" versus "buy" decision, the choice seems clear. Were we contacting for an outside vendor to come on to our campus to run a Student Health Service in one of our buildings, the equation becomes much more complex.

Meghan Gallagher, University of San Francisco

Change Management Requires Leadership Credibility and Political Capital

Most of us have lived through multiple Presidents, Chancellors, and immediate bosses. The key to not being buffeted by these changes at the top is to have allies and programs that move seamlessly from one administration to the next. A trustee or two who knows what you do can be very helpful. Employee health and occupational medicine are also good programs that will carry across changes in leadership. Because students turn over every year, you can not just rely on your student health advisory committee for ongoing advocacy.

Estelle Maartman-Moe, RN, University of Vermont

Currency is critical. Several of our teams are national contenders and several of the coaches of women's teams were concerned about eating disorders. So we hired a sports nutritionist who not only is available to all students, athlete and non-athletes, but also meets regularly with the women's teams and sees individuals privately in our office. We have seen an increase in knowledge about healthy eating on the teams and we have also seen anecdotally a decrease in disordered eating on the teams. We predict that not only have we gotten value out of adding this position for the teams, but have also garnered great support of our services from the coaches and the athletic department.

Gerri Taylor, MS, APRN Bentley College

Some of our discussion has focused on administrative priorities handed down from above, and the costs associated with those projects or programs, but we can't forget the role of our students and their value in providing advice and support as we consider and manage changes. At UNL, a student government subcommittee review and votes on our entire budget proposal each spring – even the portion not funded by student fees. The committee deliberates on line items such as new positions and even minor supplies like new trash cans. No question that Health Center Directors have a long list of constituent groups which must be attended to, but making the relevant student groups a priority has been a good strategy for us.

Jim Yankech, MS, University of Nebraska – Lincoln.

The business model of the university is changing. "Town/Gown" barriers are being dismantled. Institutional silos are being broken down. Leadership is much more sensitive to the larger public view than to the narrower view of campus interests. As we think about managing changes – whether externally driven or something we within Student Health want – we have to be as sensitive to this larger public view as we are to the concerns of the campus.

Ed Ehlinger, MD, MSPH, University of Minnesota

Gerri and Ed are making an important point. I would say it a bit more broadly – you have to be intentional in your leadership.

Robert Wirag, HSD, University of Central Florida

You not only have to be intentional, you have to clearly articulate the different benefits for different audiences. Screening for depression in primary care is translated into improving student retention and academic performance for an academic dean. It also has appeal for

"The bottom line is that we put a very significant demand on our staff to respond to a very large change and they did a terrific job. Lessons: it was critical to tell them the vision and be sure they understood the importance and validity of what we were doing. Second…you should assume good intentions and wait before you act in managing large-scale change." – CARLO CIOTOLI, MD, NEW YORK UNIVERSITY

faculty who see troubled students because they can send the student for a check-up at the Health Service and know they will be screened for depression – they don't have to get into an interview to find out the nature of the student's problem. The value of an EHR is translated into creating a virtual integration rather that a building renovation for the VP of Administration.

Nell Davidson, MD, Case Western Reserve University

Nell is absolutely right. Said in simplest terms, "What's in it for me?" where the "me" may be higher up in the organization, your peers, or junior staff who may be integral to accomplishing the change.

Carlo Ciotoli, MD, New York University

Not only is it "What's in it for me?" but also, "How do I fit into the bigger picture?You have to articulate a clear vision to everyone involved.

Sacared Bodison, MD, MBA
University of Maryland, College Park

Resistance to Change

All of this raises a core question. Most people are comfortable with the status quo, even if the status quo is sub-optimal or even dysfunctional. Remember Otis Redding's lyrics to Dock of the Bay:

> Looks like nothing's gonna change
> Everything still remains the same
> I can't do what ten people tell me to do
> So I guess I'll remain the same, listen…"

Ronald Elson, MD, University of California, Berkeley

If those ten people are telling him to do different things, sure he'll just sit at the Dock of the Bay, but if the message is simple and clear, and backed up by data, and the change is supported by the necessary structural changes, people will adapt. At some point a while back, I became aware that our appointment system was open to gaming through revisit scheduling, which resulted in some amount of "no shows." We made changes, which had our clinicians working on both scheduled blocks of time and taking walk-ins. We set a goal of having walk-ins seen promptly and having 90% of appointments seen on-time. That number is now 93%. People will change under the right conditions.

Hugh Jessop, PhD, Indiana University

I agree. Maybe moving to an open access model is easier because so many in college health have done this, but our transition was not that difficult. We did listen to what our clinician's felt they needed in terms of phone time and follow up and have tried to accommodate that.

James A.H. Farrow, MD, Tulane University

We've moved to a modified open access model. Many students who come in more than once tend to visit the same clinician. The Point 'n Click scheduling system allows students to see online which clinicians have appointments open, which has the potential to facilitate continuity of care. The downside of an online scheduling system is that you have to be prepared to monitor it pretty much in real-time to ensure appointment availability.

Ira Friedman, MD, Stanford University

The Final Word

Many years ago, Murray DeArmand and I did a presentation at ACHA entitled, "Make Dust or Eat Dust." The concept is simple: the person on the lead horse will always generate dust, but at least have clean air. You can't be an expert on everything, but where you can lead, jump on that horse.

Robert Wirag, HSD, University of Central Florida

New Leadership and Changes in Student Health Services

David McBride, MD, Boston University and D.C. Dugdale, MD, University of Washington, Seattle

Editor's Note: For this issue of Spectrum on the management of change, we thought it would be useful talk with two, newly minted SHS Directors, each about one year into their tenure. Drs. David McBride and D.C. Dugdale graciously agreed to share their experience and ideas. We then sent a transcript of that discussion to Dr. Greg Moore, who had been a new Director four years ago, and, while not quite a seasoned veteran of college health, Dr. Moore was certainly well qualified to comment on these two Directors' experience. We think you will find all three views both highly readable and very interesting.

Spectrum: Could each of you describe the process which led to your assumption of the Director position at your SHS last year?

David McBride, MD: I had worked as a physician at the Student Health Service at another university. When I decided to leave there, I spoke with Larry Culpepper, who was a friend and who directed the Family Medicine Program at Boston University, about the potential of moving to BU Student Health Service. There were still some unresolved issues of governance for Student Health, with the medical campus negotiating with the Charles River Campus, so I felt it was not the right time. I worked at Tufts for a year or so and then Larry and I revisited the BU opportunity. The position was posted, there were two final candidates, and I became the Director.

My arrival was contemporaneous with a new and unprecedented cooperation between the medical school and the Charles River Campus around student health. Historically, there was more than just the physical distance between the two campuses (about a mile). Among other things, the Student Health Service was not interested in being part of an academic medicine environment or having any substantive academic ties. At the same time, the University's administration was changing. The new leadership was committed to cooperation among programs and between campuses. So I arrived in an atmosphere of large-scale University change, a strong mandate for cooperation, and with personal sponsors on both campuses who had authority and were well respected. (Family Medicine at BU's medical school enjoys a much higher status than is found at many other academic medical centers).

D.C. Dugdale, MD: I'm a general internal medicine physician, who, from 1991 until 2004 was the Director of the general internal medicine clinic at the University of Washington Medical Center, the academic medical center located at the south end of the University of Washington campus (about 0.7 miles from the Student Health Center). This was a teaching clinic which in the 1990s, under the influence of managed care, came to have a more balanced service and patient care mandate than a purely teaching and training mission, although that has changed some in recent years as managed care's influence has waned in our region. In 2004, I took a position within the Medical Center as the first Associate Medical Director of Ambulatory Care. In 2006, I became the Director of the Student Health Service, which is part of the Hall Health Primary Care Center, which for more than ten years has been a University Health Center, providing care to faculty and staff as well as students. The process by which I took that role was quite straight forward. The existing Director was retiring and I was interested in a position that was more primary care oriented, within a health systems and public health context. It seemed to me that my existing position in the Hospital was moving away from all of those things, so I applied for the job.

It is quite interesting to think about the selection process. I don't know how many candidates they had, but it wasn't more than a few. I was interviewed by between six and 10 people, and, of course, I was known to the various "higher ups" in the Medical School and University Hospital. I was selected, but with no clear mandate to change anything. Looking back, I think there were some people involved in my selection who wanted to see a change in the way we handle mental health, but that was not mentioned at the time.

Spectrum: David, did you feel you had a mandate for change coming out of your selection?

Dr. McBride: Yes, I think everyone involved recognized that the Health Service had really had no changes in some time, and had many attributes that were more representative of past practices than current, such as our infirmary. The mandate for change was more generic than specific. If I were to paraphrase my sense of the mandate it was, "Bring Student Health up to current best medical practice."

Spectrum: Thinking back to the first month or two in the position, were there insights about required changes that you had not anticipated?

Dr. Dugdale: I actually remember this quite vividly. The leadership structure that was in place when I started was that there was an executive committee that consisted of seven people plus the Director. There was also an operations committee which include the various unit heads, and also the executive committee. At my first meetings with both committees there were clearly significant and longstanding conflicts among the leaders of the practice. It was a complete surprise to me. I had no idea this was going on. It had not come up at all in the interview process, although I must say I didn't ask. I honestly think that the leadership in the affiliated academic medical center did not know that this conflict existed (we "report" through an entity called Health Sciences Administration, which then reports to the President; but for clinical matters, we report to the QI and risk management structures of UW Medicine, the clinical service delivery arm of the UW). So I was quite surprised by the conflict among the leaders. I certainly hadn't expected it, and it is certainly not the way I'm used to working, and yet here I am and I've got to deal with it.

Spectrum: Was there substance to the conflict?

Dr. Dugdale: Oh yes, there was substance. One of our leaders, (and, by the way, everyone is still here, but happily working much more collaboratively,) is a family doc who had gradually reduced her direct patient care and focused her considerable talents more on I.T. and practice management infrastructure for the Health Center. So one of the points of conflict was that practice management information was being developed by a physician who was no longer seen as a physician who was carrying a heavy clinical case load, but still had a very strong feeling about how a primary care center should work.

Interestingly, I didn't disagree with a lot of what she was saying, but the fact she wasn't practicing, particularly with student patients, was a problem for others. So there was substance, but I also think there were style issues as well. This conflict wasn't the only problem. There were two other senior members of the management group who also had some "baggage" which contributed to the overall sense of conflict in our leadership groups.

Dr. McBride: I don't think I had any surprises.

Spectrum: The obvious follow up question is how did you deal with personnel issues in a timely, equitable and humane way?

Dr. McBride: I felt like it took forever. So what I did was to start to pay close attention to the metrics which would support my position, starting with student satisfaction. We had a number of complaints from students about a few of our physicians. We started doing surveys to get valid and more broad-based information about the experience students were having. Consistently they were saying, "The doctors are nice enough, but they are not really doing anything for me." The challenge with surveying students, of course, is that many of these kinds of complaints are common among late adolescents. Within our survey information there was some evidence that the care was out of date, so gathering student feedback was helpful in this process.

created more angst among our staff than was necessary. The pace that I set not given them time to both understand it and buy into it."

– DAVID MCBRIDE, MD, BOSTON UNIVERSITY

To get more objective data, I began to review charts, particularly for students who reported a bad experience. I also met with everyone individually to see what their perceptions were and whether they were seeing the the same kind of clinical deficiencies in selected staff. There was recognition among the staff that some of the people we ultimately let go were problematic. I began working closely with Human Resources to make the needed staffing changes. We also had the closing of the infirmary, which led to some job elimination and reassignment, and three nurses also left voluntarily, one, unbelievably, over our non-smoking policy on the premises. About eight people left who had worked in the infirmary, but many of these were part-time, as were many of the staff in the SHS. I was not convinced that this part-time model was the best one so I certainly was not replacing person for person. Unwinding all of the personnel issues took most of my first year, at the end of which I thought that fewer, but full-time, staff would be the best way to go, and I have received the necessary budget approvals to do that.

Dr. Dugdale: I certainly have not experienced the kinds of problem that David describes. If they exist here I have not found out about them yet. Despite the sub-optimal things that were going on here, the clinical quality of our people and the care being delivered was quite good. What was lacking here, was what I would call a 21st Century approach to quality improvement. For example, we have a very nice EMR, Epicare, and yet we hadn't really used it to streamline and standardize care. When we examined our experience for UTIs in women 17 to 65, some 1,600 cases for the academic year 2006-07, although we had a practice guideline, it mostly wasn't used. In my mind, that was the result of our Clinical Director not having the tools needed to address this and our Associate Director for IT not having the clinical connection to make it happen either. It is not as though the care was inappropriate from a clinical viewpoint, because deviation from a single practice guideline is acceptable, and sometimes common. What was missing was the will and support to sit folks down and say can't we make our practice more efficient, and, by the way, stop ordering hundreds of urine cultures which cost the students money, and stop using Cipro as the first line treatment drug, when our guideline says something different. These questions just had not been articulated, and by just bring them to the forefront, I think we've begun to change our approach to quality.

Dr. McBride: I agree and I can tell you that the concept of evidence-based medicine was quite foreign to the staff here. They relied heavily on the pharmaceutical company representatives for education on current best practice, and the sample closet prompted the first choice for drugs. We had huge antibiotic over-utilization. But when you step back and look at it, it is very hard to argue with evidence, and that is the approach that I'm trying to take. I am not trying to eliminate individual practice variation, but trying to steer people toward what the evidence suggests is appropriate.

Dr. Dugdale: Our Clinical Director is very sharp, a very well-respected physician, who certainly has the clinical knowledge and skills to discern best practice. The problem, which is common in physicians who take on a management role, is that she had not had either the training or the mentoring on what are the appropriate tools to handle challenging clinical issues mixed with interpersonal relationships. What's exciting and gratifying is that she has come along nicely on those as well. Part of our success in this was that I arranged to have a retreat facilitated by a person who is also an expert on organizational conflict. One step was focused work on the relationships of our leaders, including between the two people who had the most conflict. I am very pleased that both of them have really tried, as have all of our leaders. What I've learned is that conflict resolution does not come naturally and there are resources, which here existed within the University, which can really be helpful.

Spectrum: Dr. Dugdale raises the interesting question about the use of resources external to the SHS to help with the change management process. Let's expand that to include literature resources you have used and perhaps shared with your staff.

Dr. Dugdale: After a month or two I realized our operations leadership group was not really functional. I felt they needed to bring in clinicians and work with them on clinical problems, facilities resources or people for those kinds of issues, and systems people to address systems needs. Obviously, the operations leadership group also had to perform an integrative function. What I felt had to happen was for them to work out a better way of functioning that either resolved or avoided the internal conflicts, and also became more focused and task-oriented, but I wanted them to do this on their own. So, as I mentioned, I put together a retreat for our management group. As that was being planned, the facilitator, who is a University resource, came to me and said, "We have a real problem here, everybody tells me that the conflict between these two doctors gets in the way of the group functioning. What are we going to do about this?" My reaction was to let these individuals hear this directly

Leadership and Change in Student Health

Gregory R. Moore, MD, MPH, University Health Service, University of Kentucky

Much like Dr. McBride, I came to student health at a time of change. The University of Kentucky had just reorganized under a provost system and University Health Service (UHS) moved from the College of Medicine to Student Affairs. My predecessor, Dr. Spence Turner, had worked diligently for at least a decade to remedy a serious shortage of space. The reorganization seemed the ideal time for the final push to obtain funds for a new UHS building. After months of heart-stopping advances and setbacks, we finally got the necessary approvals and will move into our new and dramatically expanded building this spring.

Regardless of reporting structure, student health services at academic medical centers always serve two masters. The College of Medicine understands the complexity of medicine and, more importantly, the cost of medicine. Student Affairs always has the student's well being as their number one priority. The College of Medicine has the money, but when thrown into the battle of competing priorities, Student Health usually doesn't fare well. Student Affairs frequently struggles financially, but has the desire and ability to intervene quickly when the health or welfare of a student is threatened.

I can empathize with the struggles of Drs. McBride and Dugdale regarding personnel issues. I found a similar situation when I arrived at UK. My final tour in the US Navy involved supervising 178 clinicians. For the most part, they were young, eager and well-trained. Serious personnel issues were few and far between. Clearly there are many extremely bright, hardworking and gifted individuals working in college health, but I do think we have far more than our share of clinicians who view college health as semi-retirement. Modern ideas (actually necessities) regarding quality assurance, electronic medical records (EMR), cost containment, and evidence-based medicine are often looked upon with suspicion.

Introducing a "21st century approach," as Dr. Dugdale puts it, requires creative thinking, expert management and time. I have found that the staff falls into three broad categories:

1) Those who will never get it,

2) The forward thinking, early adopters, and

3) Those who need a little push, but are quality people and will help advance the mission of the institution given the opportunity.

There is probably little you can do with those who will never get it. It is best to help them find a position that better suits their interests. The early adopters are your strength. Enlist their help. Cultivate their abilities. Articulate your goals and give them free rein. You will be amazed *between Student Life (also called Student Affairs on some campuses) and here they are very different."* – D.C. Dugdale, MD, University of Washingon, Seattle

from each other. We got them in a room with the facilitator, but I stayed out of this, although I did meet with each of them individually, prior to the meeting to explain that we needed to resolve this and move on. The facilitator is very seasoned and experienced in working with health professionals. She also has a low tolerance for mind games, and quickly cut through the mutual blame game. And it worked, it was the intervention that was needed.

In addition to the outside facilitator, and as part of my work with our leadership group, after three or four months I said, we are going to restructure the operations group and I've become aware that there are a number of leadership skills that I think we could all benefit from by learning together. So I put together a year-long leadership training program for our executive committee. I reviewed the literature and taught most of these sessions, although I did have someone come from personnel on human resource questions, and I had our CFO do the finance part (I was amazed that most of our leaders did not understand the finances at all). For the past year, the executive committee has met once a month for an hour

COMMENTARY

at what can happen. Success breeds success and others will join in as they see benefits from what is happening.

Both Drs. Dugdale and McBride see exploiting the full potential of the EMR as a priority. I am in the midst of that process myself. The EMR seems to have taken on a mythical status. The question, "Are you using an EMR?" echoes through the room whenever college heath directors gather. Just what is meant by "EMR" however, can be fuzzy. Many regard an "EMR" as a system in which their dictated notes are simply transcribed in electronic form rather than paper. Others see it as a program that performs business functions and documentation of basic medical outcomes, such as frequency of various diagnoses. I see it as a necessarily flexible system that requires little or no dictation or typing, but rather relies on templated notes, clinical databases, and evidenced-based practice plans. A truly useful EMR must not only document what happened in the exam room, but allow for quality improvement, peer review, improved efficiency and practice management.

Appropriate use of medical resources is a challenge for our nation in general and student health in particular. It is a life-skill that, if mastered, will benefit not only our patients but society. Our Student Affairs colleagues stress that most of the valuable lessons learned during the college experience are not primarily learned in the classroom. One seventh of the US economy is related to medicine. If our universities are to adequately train future leaders, students must understand medicine and we must help. Doing so, however, will be incremental, rather than transformational. We need to seize every opportunity to educate our patients about appropriate care, health insurance, cost containment, and exactly what medicine can and can't do.

My advice to someone assuming the role of SHS Director in the next month would be: Take time to survey the situation, understand the politics and make a plan that can actually be accomplished. However, don't wait too long to start moving the organization forward. Everyone expects changes will come with a new Director, but the honeymoon period can be brief. Most importantly, enjoy what I consider the ideal job. There are few opportunities to make such a difference in so many lives.

Gregory R. Moore, MD, MPH is the Director of the University Health Service at the University of Kentucky. He received his MPH from the University of Pittsburgh and his MD from the Uniformed Services University. He is board-certified in OB/GYN and served in a variety of clinical and operational positions in the US Navy, most recently as the Medical Director at the Naval Hospital, Camp Lejeune, NC. He can be reached at grmoor2@uky.edu.

"[In the next 18 months,] I would like to fully realize the potential of our quality improvement. It should also help with discussions on productivity and

and we have a curriculum. The change management part was developed by borrowing references from friends of mine who had done something similar, and adapting it to our environment.

Dr. McBride: I would say in looking back that this has also been a management learning experience for me. I became the Medical Director for a community health center very soon after residency and did not have either management experience or even management training. I continue to grow as a manager. Your resources are appreciated.

Dr. Dugdale: I'll forward you my short list (*Editor's Note: Dr. Dugdale's list is cited at the end of this discussion on page 34*), but one individual whose work I found quite useful is John Kotter at the Harvard Business School, who is one of the people who made change management a field of academic study. I was quite fortunate, about ten years ago, when the Medical Director at the UW Medical Center suggested that I take a course in medical management. I did that, and my prior experience was essentially like yours – I started directing a medical clinic directly out of residency. Although I had picked up some knowledge and skills along the way, I had some pretty serious gaps in my management skills. The program is a certificate program at the University of Washington designed for people in medical management positions in mid career (although some were early career) who needed to learn some management skills. Later, when I was Medical Director of the outpatient department, the Medical Director of the Hospital, who believed that academic physicians needed to learn management and leadership skills, asked me to join him in developing a course for academic physicians in the Hospital. That teaching experience also provided some of the content for what I put together for our leadership group's year-long seminar series. I have to say that working with a leader, as I did, who really was passionate about management and leadership skills certainly helped me tremendously.

Spectrum: What are the two or three things you would like to accomplish in the next 18 months?

Dr. McBride: I would like to fully realize the potential of our electronic medical record, which I really think will help with process and quality improvement. It should also help with discussions on productivity and the appropriate use of time. It also will permit the mapping of visits so that we'll know if we are spending the appropriate amount of time with patients.

Dr. Dugdale: I have a similar priority in terms of our electronic medical record. A second thing that is on the top of my list is to take what was a very successful QI project with UTIs and to gear up that structure to handle some of our other significant clinical challenges, depression being high among them. It took us quite a long while to get through the UTI process, so this year I've only given the guidelines committee two large problems to consider: depression and pharyngitis. Hopefully they have learned from the UTI work that a structured approach works and is supported by our electronic medical record.

Finally, we really have not ever addressed productivity here. In a way, I am glad I did not have to start with this. Our productivity might be considered reasonable, although I think it's pretty low by community practice standards. We're a group where most people do what they are supposed to do, but unfortunately we have a few outliers, who have been allowed to continue their practice style. I have been working to develop the metrics which will allow me to deal with this, but I have not yet figured out the best way to get this done, so that becomes the third major task I need to get done this year.

Spectrum: It is interesting that both of you have as priorities becoming more efficient and effective at managing the demand for health care and other services that present at your doorsteps. What about activities, programs, interventions which might change that demand load – to increase it for students in need who are not presenting, and decreasing it for those students who are either overusing the SHS or who may be unaware of appropriate self-care alternatives. Said another way, what about the public health, health education, and demand management components of the job?

Dr. McBride: We are doing that, although I don't know if I believe in demand management for student health, to tell you the truth. It is such a complex issue, particularly for this population who has such limited knowledge about their bodies and about the health care system that they don't know when it is appropriate to come for care. I don't think I'm ready to advocate that some students not come in for care, although we are in the process of designing an educational program for all students which hopefully will improve their basic health literacy. We are trying a few things such as electronic media with individualized feedback for things like alcohol abuse and nutrition. What makes it difficult is that this population is so engrossed in their academic experience, and appropriately so, it is hard to work a co-curriculum into that experience without them feeling information overload. I did find it interesting that Greg Moore at Kentucky had worked to develop a freshman course in life skills. It is a very interesting concept, but one which I think has to be incorporated into the mainstream academic experience, using things like writing classes. In my mind that is the best way to engage students while they are in the class room. If you are going to write, why not write about health choices?

Dr. Dugdale: In our UTI project several people said, "Why don't we treat these people over the phone?" which is quite common in adult medicine practices. We may get there, but I have the same concern about the health knowledge of many of our students as David does, so I am not sure that telephone treatment is the best thing for them.

Another consideration is that, as currently structured, we do not get reimbursed for telephone visits, so we would take a financial hit even if we felt it was clinically appropriate for a student population.

This year we are experimenting with a freshman seminar that will be partly taught by one of our docs. Our new VP for Student Life is particularly interested in this and has asked us to help with the content. We are not seeing this course as something that would reduce student demand for health services, but more a new venture into the area of student health and wellness. In the mental health area we do have some tools on our website that are designed to help students understand that some of what they may be experiencing in terms of stress and anxiety may well be part of the normal adjustment to college life and or relationships – what some call a "normative life crisis" as opposed to a disease. My Mental Health Director tells me that many students come in, although they are not at all clear that they should come in. Some, of course do need care, but many do not, although they do need support and reassurance that what they are experiencing is okay, and what is lacking is their experience to know how to deal with it. (*Editor's Note: Dr. Sidney Garfield, the first Medical Director of the Kaiser Permanente System, wrote in Scientific American in April of 1970, in an article entitled, "The Delivery of Medical Care," about the need to care for the "Worried Well." Dr. Garfield suggested that the care for the "Worried Well" population was support and education on the techniques for managing concern and stress. This is quite similar to what Dr. Dugdale is describing here.*)

Spectrum: In the year or so you've been the Director, can you tell us about something that has worked surprisingly well? And to bracket that good story, is there something that you'd like to have the opportunity to do over?

Dr. Dugdale: I know I keep mentioning our work on UTIs, but that effort was a success in many ways, perhaps the most important of which was that it brought a new leader to the forefront, a physician who was Chair of the Guideline Committee. The problem had been that the Guideline Committee had never been empowered to examine what the impact of guidelines actually is on practice. She has now really grabbed the bull by the horns on that. This, of course raises the potential for conflict between her and the Director of Clinical Affairs, and I have to be mindful of that, but she has really stepped up and made this a great process for all of us because she has been so committed to it.

Dr. McBride: I think two things have worked well for us. First, most of the remaining staff have really embraced

"We see about 60% of those patients who want to be seen on a given day, on at least in the Seattle area. But I'd like to do better than that." – D.C. Dugdale, MD,

the changes to improve and offer clinically appropriate care to our students. Their willingness to change has been very encouraging. I think that they had a readiness to change before I arrived, and in many ways felt constrained under the old system. The other great success was that I was able to hire a fabulous Director of Behavioral Medicine, who had spent 25 years working at MIT and then at the Cambridge Health Alliance. She's motivated the behavioral medical staff to get out into our campus community with a variety of outreach and educational programs, while also creating liaisons to other community resources. The work that she has done in a short period of time has been incredibly gratifying.

Spectrum: I'd like to underscore your point about unleashing the potential of staff who may have worked in an inefficient system. I think it's a real tribute to your leadership that you empowered these people to participate fully in the new vision for student health at BU. Often, in turnaround situations, the old "regime" is discounted, at a significant price to both those individuals and to the organization at large. What about decisions that did not work as well as you would have liked?

Dr. Dugdale: We have had a number of discussions around access, and while I think these have been useful discussions, I have not, as yet, been able to get the full engagement of our leadership on this. Part of this is that our access is pretty good by community standards. We see about 60% of those patients who want to be seen on a given day, on that day. Most primary care practices don't do that well, at least in the Seattle area. But I'd like to do better than that. We're still leaving 40% who would like to be seen without access, although we spent enough resources on triaging them so we know that it is safe for them to wait until the next day, or the day after. I don't know what the best approach is to move this forward. We've measured it, the 60% finding came out of a project we did to put some metrics around the problem, but we don't yet have people engaged on the need to improve this.

Spectrum: So less a misstep, and more of a work in progress?

Dr. Dugdale: Perhaps, but I worry that I just didn't go more on the conceptual side to start with advocating Don Berwick's open access model. However, our staff said we don't know how to measure access, so I guess we had to start there.

Dr. McBride: I think for me, my coming in with an incredible amount of motivation and high energy probably created more angst among our staff than was necessary. The pace that I set was too fast for some folks, largely because my vision was very clear to me, but I'd not given them time to both understand it and buy into it. So two things I'd do differently: I'd communicate the vision much more carefully, and because my pace was so much faster than theirs, I'm afraid I gave them the sense that they were disappointing me. I'd be very careful that good people working hard didn't think they were disappointing me. In looking back, I think understanding those issues and addressing those wounds directly has contributed to my growth as a manager.

Spectrum: The issue of addressing the dissonance between the pace of change of a new leader, and the ability of the organization to "metabolize" that change vision is critical. It is among the most common of problems that a new manager will face. One has to create a sense of excitement and urgency, while avoiding the dual staff reactions of "that guy is crazy if he thinks we can do that" and/or "I'll never be able to keep up this pace." In some ways you have both described the "bookends" of this dilemma – D.C. worries that he has not created a sense of urgency about access, and David reports he left some folks feeling they were in the dust as he moved forward. Great discussion.

Final question: If someone were assuming the role of an SHS Director next month and called you for advice, what would you say?

Dr. Dugdale: The one thing I wish I'd known and understood better was the relationship between Student *that day. Most primary care practices don't do that well,*

UNIVERSITY OF WASHINGON, SEATTLE

Life (also called Student Affairs on some campuses) and the Health Center. I know on some campuses they are one and the same, but here they are very different. Last year the VP for Student Life retired, and a new person has taken his place, and that has created lots of opportunities for better relations between Student Health and Student Life. Said in the broadest terms, if someone were to call me, I'd say, "Try to understand all of the politics and relationships before you begin."

Dr. McBride: I'd underscore that, and I'd say that our very positive relationship with Residence Life has been one of our greatest strengths. Primarily, this solid relationship has been built through our Crisis Intervention Counselor. If we did not have this strong relationship with residence life and with the Dean's Office our work would be much more difficult. So my advice would be, "Meet with the Student Life people as one of your first meetings."

Spectrum: Thanks for a very useful discussion.

David C. "D.C." Dugdale, MD, is Director of Student Health Services for the University of Washington, Seattle. Dr. Dugdale graduated from the University of Pennsylvania School of Medicine, and completed residency training in internal medicine at the University of Washington. He was formerly the Associate Medical Director for Ambulatory Services at the UW Medical Center. He is a fellow of the American College of Physicians and has served on the Council of the Society of General Internal Medicine. He can be reached at dugdaled @u.washington.edu.

David McBride, MD, is Director of Student Health Services for Boston University in Boston, MA. After studying at Miami University and the University of Pittsburgh School of Medicine, he completed his residency in Family Medicine in York, PA. He is a member of the Phi Beta Kappa and Alpha Omega Alpha honor societies. On moving to Boston, he was Medical Director for Lynn Community Health Center in for five years, and then moved into college health and medical education. He is an Assistant Professor of Family Medicine at the Boston University School of Medicine in addition to being the Director of SHS. He can be reached at dmcbride@bu.edu.

Annotated Bibliography

The following is an annotated bibliography of a number of useful references as cited earlier by Dr. Dugdale:

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Case-based work on health management

Kotter JP. "Leading change." *Harvard Business Review.* 1995 (March): 59-67

Considered to have laid the foundational concepts for change management as a field, in both corporate business and academia.

Sirkin HL. "The hard side of change management." *Harvard Business Review*. 2005 (Oct):109-118

Based on a study of 225 companies, describes four key factors affecting project success (project duration, project team capabilities, leadership/staff commitment, additional effort required by the change)

Transitioning to an Integrated Enterprise Electronic Health Information Management

Sallyann M. Bowman, MD, FACP, University of Pennsylvania

Editor's Note: Most College Health Services have either implemented an electronic health record, or are in the process of doing so. For the later group, Dr. Bowman's article, particularly the last section, "Lessons Learned," should be very helpful. But there is also something for those who are a year or two into using an EHR. In her conclusion, Dr. Bowman says, "there is really no such thing as one change." She goes on, "This is a dynamic process of change which is enhanced by actively using principles of performance improvement, group dynamics, adult learning, and, above all, communication." This reminds us of Dr. Steve Shortell's comment in a chapter he wrote in Alain Enthoven's book, Toward a 21st Century Health System, where he said, "To use a biological analogy, teams are the RNA that links the medical group structure (or protein) with the DNA of clinical information and knowledge. It is not the information itself that integrates care, but rather the team that uses the information, including the patient as a central member of the team."

In 2004, the leadership of the Student Health Service (SHS) at the University of Pennsylvania made a strategic decision that conversion to an Electronic Health Record (EHR) would best serve the mission goals of best practices in medical care, compliance with HIPAA privacy and security regulations, and maintenance of the Joint Commission accreditation as an ambulatory care facility. The following discussion highlights several of the key steps in the process that allowed us to successfully integrate clinical and administrative functions in an electronic environment. The comments are written from my perspective as a member of the clinical team involved in the process.

Step 1: Needs Assessment

The broad functions of direct patient care and management of the student health insurance and immunization compliance programs were considered critical to be supported in an integrated electronic environment. This integrated data management system would need to have a bidirectional communication with University student registration and financial systems. Also critical was the ability to utilize the Internet to allow two-way communication with students, either through e-mail or a secure server across the spectrum of the clinical and administrative services.

The desired system would need to be:

- 1. Consistently available (to minimize system downtime),
- 2. Secure, preferably within the University firewall,
- 3. Reliable, with minimal compromises to data integrity,
- 4. Adaptable to the needs of various levels of end-users, from novices to super-users,
- 5. Affordable,
- 6. Flexible, allowing for integration with external systems and, lastly,
- 7. Consistently supported by the software vendor from installation and start-up through ongoing maintenance and enhancements.

Step 2: Vendor Selection

With these goals in mind, a request for proposals was developed with input from leadership, administrative management, information technology and clinical representation. Four vendors responded to the RFP. Small teams of users interviewed the vendors, viewed demonstrations and made recommendations to Student Health Service leadership regarding their preferences. Key among the concerns of the selection teams were issues of accessibility, reliability and translation of work processes in place at the time to the new electronic environment. The ultimate successful vendor was able to address the concerns of administration and staff to their satisfaction.

Step 3: Installation

Once chosen, the vendor worked closely with local SHS information technology staff and University technology support to ready the supports necessary to make the change. New servers were purchased, and an off-site location was found for back-up servers. New desktop workstations were planned in advance and installed two months before the scheduled conversion.

"This is a dynamic process of change that is enhanced by actively using principles of performance improvement, group dynamics, adult learning and, above all, communication."

Key decisions were made and steps taken during this preparatory period between vendor selection and deployment:

a) As much data as possible in the existing practice management system would be converted to the new system, including, but not limited to, appointment history, diagnoses, procedure codes, immunization and insurance history;

b) Clinical and administrative workgroups were established to review operations and determine where adjustments would need to be made to provide 'good fit' with the new operating system;

c) No attempt would be made to include clinical information in existing paper charts by scanning or manual data entry beyond that listed above;

d) The inaugural group of 'super-users' was identified for each administrative and clinical workgroup to go through initial training and then deploy locally, recruiting local expertise in various departments to assist with deployment and on-going operations;

e) Deployment and subsequent upgrades were timed to occur during relative 'downtimes'.

Step 4: Managing the Change

Throughout the steps described above, there was a concurrent process of anticipating and managing the dynamics that would be needed to result in successful adoption of the change.

a) Ongoing communication: Management and the 'super-users' were encouraged to be in close communication with the entire staff to keep them involved and informed of the progress, no matter how small the changes were from week to week. No less than bi-weekly preparation meetings preceded the deployment;

b) We encouraged end-users to articulate their specific needs and fears. Reassurance was regularly provided through demonstration of how doing their jobs would be easier and better if they could adopt the change;

c) The most critical step required an intensive analysis of work-flow processes, i.e. What do we need to do? How are we doing it now? How will this need to be accommodated, or changed, using the new system? How will the changes in procedure flow across different workgroups?

d) Encouraging end-users to anticipate how their tasks would be accomplished before the transition, for example, scheduling appointments, documenting encounters, processing laboratory specimen collection, etc., helped to identify the potential problematic areas before the actual deployment and address them with system customizations, where possible. This included encouraging experimentation before the deployment and discouraging users from developing personal 'work-arounds' to complete tasks;

e) Throughout the process, resistance to the transition to a new system occurred. In some cases, the resistance was coming from personalities that inherently feared change, from individuals who were fearful that their discomfort with 'computers' would be unmasked and that their clinical performance would be compromised, or fear that typing skills would slow their productivity or increase the time needed to complete familiar tasks;

f) Training included that provided by the vendor, which, once in motion, we learned would be through the 'train the trainer' model. Subsequently, several methods of training users were effected through small group sessions by workgroup, brief, targeted lessons delivered by Powerpoint presentations by e-mail, as well as 15-minute 'mini in-services' and on-to-one individual instruction for some when they presented with specific needs. The latter strategy was particularly useful; once the immediate problem could be solved, the learner was generally more open to learning one or two more 'tricks' for using the system.

"Essential...was demonstration of consistent and steady reassurance from leadership that the change would be beneficial and that we, as an organization, would ultimately be successful."

g) Essential to all of the above was demonstration of consistent and steady reassurance from leadership that the change would be beneficial and that we, as an organization, would ultimately be successful.

The Aftermath

Since deployment of the new system some 27 months ago, we have been able to eliminate paper documentation of clinical encounters, open a secure Web portal that enables on-line completion of insurance and immunization forms, appointment scheduling, and messaging.. During our annual staff retreat held in early January, 35 of 50 (70%) staff members in attendance rated the change to the new system as "a very good" or "excellent change". The percentage was close to 90% for those present at the time the transition occurred.

Lessons Learned

Of course, there were things that could have gone more smoothly than they did. The following discussion is presented to analyze some of the things we might have done differently, but is in no way meant to diminish our high level of satisfaction with the selection of the system and the vendor.

1. Although we discussed requiring a 'proof of concept' from the vendor before contracting, we did not follow through with that requirement. We might have avoided an almost four month delay in deployment if the complexity of the data conversion, eligibility insurance plan calculations, immunization compliance formulations, and tunneling through University security firewalls had been identified during a trial process. We also might have benefitted from making our site visit to schools already using the system prior to contracting. However, it was still highly valuable to spend time with a Student Health Service successfully using the system prior to deployment from the perspective of assessing how our internal procedures and systems would need to be 'tweaked';

2. As is often the case, what the vendor describes and provides in training is not what we had envisioned. The vendor staff executes an intense on-site installation and training effort for several weeks. But the "see one, do one, teach one" method of training doesn't work well for everyone. We might have benefitted from a more formal assessment of end-users to identify their needs for skills development and readiness to work exclusively in an electronic environment.

3. We were fortunate to have had several clinical staff members, doctors, nurses, and office managers that were very knowledgeable about and comfortable with working with the technology that were instrumental in helping to get the clinical operations up and running with an 'unofficial' roll-out of the clinical portion of the system. However, there is an on-going need to identify and train clinical leadership to maintain and 'groom' the system for maximal efficiency and ease of use. There is also a significant value in having many members of the clinical team involved in the daily operations of system management. This broadens investment in the change, rather than concentrating expertise in one or two individuals who can become over-committed to managing the technology and taking them further away from actual clinical care. It also provides a stable of clinicians with the skills to assist in management in the event of inevitable departures.

4. Finally, there is really no such thing as one change. The transition to a new data management system has been successful. But, along the way, there have been subsequent changes that have derived from it that could be a much larger discussion. This is a dynamic process of change that is enhanced by actively using principles of performance improvement, group dynamics, adult learning and, above all, communication.

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Sallyann M. Bowman, MD, FACP, is Deputy Director for the Student Health Service at the University of Pennsylvania, a position she has held since 2005. She also serves as Associate Professor of Clinical Medicine at the University of Pennsylvania School of Medicine. Dr. Bowman received her BS from Chestnut Hill College in Pennsylvania and her MD from Pennsylvania State University. She is board-certified in Internal Medicine and is a frequent writer and lecturer. She can be reached at sbowman@exchange.upenn.edu.

Beyond Insurance: Expanding Student Involvement in University Health Services

Burton O. Cowgill, PhD, MPH and Kristin Elizabeth Yarris, MPH, MA

Editor's Note: A significant factor in institutional change in college health programs should be input from students. Burt Cowgill and Kristin Yarris describe here the evolution of the Student Health Advisory Committee at UCLA. Although not stated expressly, the authors describe the empowerment of the SHAC through the respect they are accorded by the Student Health Service, the administration and a variety of groups on campus. The fact that members of the SHAC receive stipends is more than symbolic, and is no doubt part of their empowerment. Finally, nothing is as empowering as results, and here the authors describe several examples of the SHAC's direct involvement in change. SHACs, by definition, are more subject to change in membership and leadership than the programs and staff they advise as students graduate and new students matriculate. This process of bringing new voices, new questions, and new ideas to Student Health is essential, and UCLA seems to be doing this very well.

Mirroring trends in broader U.S. society, university health programs are currently facing significant challenges to maintain and/or extend the provision of quality medical services to a patient population of students who present ever-changing health care needs. Because of rising health care costs and with increasing numbers of students demanding expensive prescription drugs, the financial pressures on university health insurance programs are intensifying.[1,2] In order to meet the goal of the American College Health Association to "advance the health of all students and the campus community" in the context of the growing complexity of student health care needs, university administrators will need to find creative ways of maximizing available human and fiscal resources to promote student health and wellbeing along with a healthy campus community.[3]

One such innovative approach is to encourage student involvement in the development and ongoing oversight of university health services and other health-related programs on campus. As the primary users of campus health services, students can provide university administrators valuable input about their needs related to illness prevention, health promotion, and clinical care. Furthermore, participation in the oversight of student health services provides students a broad and informed understanding of the range of issues involved in implementing health services at a university and can thus facilitate valuable dialogue between students-patients and university and health center administrators.

Here we discuss one example of how to increase student involvement in university health services and related programs by drawing from our experience with the Student Health Advisory Committee (SHAC) at the University of California, Los Angeles (UCLA). After providing a history of the UCLA SHAC, we review its organizational structure, discuss the mechanisms it has employed to fulfill its mission of overseeing student health services, and describe some of the benefits and challenges faced in attempting to enhance student input into university health-related programs. While our experience is particular to UCLA – a large, diverse, urban university – and may not be applicable to all college settings, we hope that others can learn from this discussion and feel encouraged to creatively implement programs such as these to increase student involvement in health services programming in their own unique campus community.

UCLA

UCLA is home to over 38,000 students – 25,432 undergraduates and 12,786 graduates, interns, and residents.[4] The student body is widely diverse, with students originating from California, elsewhere in the United States, and many international countries. Some students are fresh out of high school, some are transfers from other colleges, others are returning for advanced graduate degrees after years of professional experience. Some students are parents; some are married; while others have never experienced a serious intimate relationship. All of these students share something in common: they attend UCLA, form part of the UCLA campus community, and access some or all of their health care-related services through the university system.

"Because of rising health care costs and with increasing numbers of students health insurance programs are intensifying."

The Arthur Ashe Student Health and Wellness Center (the Ashe Center) serves as the hub of this system, with 22 doctors, 17 nurse practitioners, and one registered nurse serving the entire student body. Additionally, the Ashe Center provides pharmacy, lab and x-ray services, as well as physical therapy, acupuncture, and other mind-body services. Health insurance is compulsory for UCLA students, who are required to either enroll in the Student Health Insurance Plan, or to actively waive out of the UCLA plan by verifying they are covered by comparable insurance. Students also receive other health, mental health, and related support services through several additional University-funded programs, including: Student Psychological Services, the Office for Students with Disabilities, and the Center for Women and Men. Finally, many UCLA students participate in University-sponsored and other on-campus programs and activities that are health and wellbeing-related, such as fitness or yoga classes at the John Wooden Recreation Center, groups and workshops through Student Psychological Services, or student health advocacy through involvement in one of many UCLA student health-related groups.

UCLA's Student Health Advisory Committee

Since 1972, the UCLA Student Health Advisory Committee has served as the primary body for representing the student voice on campus issues related to student health. SHAC's original mission was: "to ensure that UCLA student health interests are represented in the development of health care policies and programs, so all students will have access to high quality, efficient, and cost effective health care." In other words, the central focus of SHAC since its inception has been to provide input into clinical care programs offered at UCLA. As part of this responsibility, SHAC has provided a student perspective in the student health insurance renewal process. Over the past few years, SHAC's purview on campus has expanded, with SHAC outreach and activities shifting to focus on additional programs related to overall student health and wellbeing, not only clinical services. These changes, and the related benefits and challenges, form the basis of the discussion that follows.

SHAC Organizational Structure

The organization and internal structure of the UCLA SHAC has allowed the committee to recognize emergent issues in the ever-changing campus health care landscape and to respond effectively and efficiently to the needs of the student body. SHAC is composed of eight student members – four undergraduates and four graduates appointed by their respective student governments. The term of service for SHAC members is two years. A stipend is provided to each SHAC representative, signifying the importance the University assigns to SHAC and the expectations accompanying the position. Two University representatives, one from the Ashe Center and one from the Office of Student Development, serve as staff advisors to SHAC, participating in SHAC meetings as non-voting members, and offering guidance and assistance as needed. The committee meets at least four times each quarter to discuss ongoing business, to review findings from student feedback mechanisms, and to identify areas concerning student health and wellbeing that need to be addressed. All official SHAC meetings are open to concerned members of the campus community, conducted following Robert's Rules of Order, and a quorum of five student members is necessary for any vote to occur. Four subcommittees permit SHAC members to divide primary responsibility for moving forward with actions steps. The committees include: Budget and Insurance, Campus Outreach, SHAC Development, and Student Health Related Organizations. SHAC members also participate on the Student Health Insurance Committee (SHIC), which annually reviews the Student Health Insurance Plan.

Student Health Services Oversight

Central to SHAC's mission is garnering student input related to improving the quality and effectiveness of student health services provided through the Ashe Center. To this end, the Ashe Center administrative staff had established a fairly standard comment card process, whereby students may voluntarily fill out a hand-written card after clinical visits and leave it in one of the collection boxes located on each clinic floor (see *Table 1* for a description of the comment card and other oversight

Table 1: SHAC Oversight Mechanisms	
Mechanism	**Description**
Student Health Center Comment Cards	On a quarterly basis, SHAC reviews comment cards voluntarily submitted by students collected at the Ashe Center and by an online comment process.
Web-Based User Surveys	On a quarterly basis, SHAC reviews the results of a web-based survey of a random sample of students who have utilized the Ashe Center the past quarter.
Participation in SHIC	Annually, SHAC members participate on the Student Health Insurance Committee that reviews the renewal of the Student Health Insurance Plan.
Budget Expenditures	On an as-needed basis, SHAC reviews budget proposals related to the expenditure of funds for health-related services and programs on campus.
Health-Related Proposals	On an as-needed basis, SHAC reviews proposals related to adding, changing, or removing health-related services on campus and takes appropriate action.

mechanisms). While the existing procedure resulted in an average of 12 cards submitted per quarter, student feedback to SHAC suggested that this mechanism did not adequately capture the range of student experiences in the Ashe Center. Thus, two years ago, SHAC decided to reexamine the comment procedure, seeking to make the cards more accessible and to raise student awareness about the process. SHAC also investigated patient feedback modalities employed by Student Health Centers at other colleges and universities, finding a range of existing possibilities – from clinician-solicited feedback to no comment mechanism whatsoever. After discussions with Ashe Center staff about the potential implications of various comment procedures, SHAC determined that the most appropriate way to increase student feedback was to make comment cards accessible on-line at the Ashe Center website. This change – accompanied by a word-of-mouth campaign to raise student awareness of the comment procedure – resulted in a significant increase in the number of cards submitted, up to an average of 30 in the quarters following implementation of the on-line process.

In addition to the comment cards, SHAC also monitors student experiences with the Ashe Center by reviewing results of a Web-based survey of a randomly selected sample of patients conducted each quarter by Ashe staff. Within the last two years, SHAC instituted the practice of systematically reviewing results of these surveys to gain additional insight into Ashe Center user satisfaction. The survey provided descriptive data of student-patient demographics (i.e. percentage graduate vs. undergraduate, male vs. female, ethnicity, and age), utilization of specific services (i.e. women's health, sports injuries, immunizations, contraceptive services), and overall measures of student satisfaction (i.e. with scheduling, appointment availability, and clinical care). The results demonstrated that, while overall patient satisfaction with the Ashe Center was high, there were areas in need of improvement around which SHAC could mobilize. For example, results from one survey indicated that students were experiencing exceptionally long wait times and occasional breaches of confidentiality at the Ashe Center pharmacy. After reviewing this data, SHAC quickly moved to strengthen our relationship with the Ashe pharmacy, working with the pharmacy Director and staff to improve student awareness of the pharmacy delivery process, to develop new mechanisms for determining readiness of prescriptions, and to change the wait line configuration to better protect patient privacy.

Campus Outreach to Improve Student Health & Wellbeing

While oversight of the clinical services provided by

Table 2: SHAC Outreach Efforts	
Mechanism	**Description**
SHAC Liaison Positions	SHAC members serve as liaisons to campus organizations and groups to establish open lines of communication about issues pertaining to student health and wellbeing.
Campus Newspaper	SHAC places advertisements in the *Daily Bruin* to highlight changes in health service delivery or to publicize available campus services. The ads also increase SHAC's visibility.
Campus Health Fairs	SHAC members attend health fairs to provide information on SHAC's role on campus and to listen to student concerns about health-related services and programs.
SHAC Email and Voicemail	SHAC maintains an email and voicemail system so students can share their concerns or raise questions to SHAC.
SHAC Business Cards and Flyers	SHAC hands out business cards and flyers to individual students and places them in strategic locations around campus to increase awareness among the student body.
Open SHAC Meetings	SHAC meetings are open to the public so students can attend and ask questions about health care services on campus.
Attending ACHA	SHAC members began attending the annual ACHA conference in 2007 to share experiences with SHAC representatives from other Universities.

the Ashe Center is central to SHAC's mission, in recent years, SHAC has prioritized developing the student advisory role in other campus programs and activities related to student health and wellbeing. To do so, SHAC realized it needed to build stronger working relationships with a number of University programs and health-related student groups.

One of the methodologies developed by SHAC to formally outreach to the campus community was the institution of liaison positions (see *Table 2* for a description of this and other outreach mechanisms). By designating SHAC members to serve as liaisons to specific departments and groups, SHAC's goal was to establish open communication and strong working relationships with these campus entities. The groups included UCLA administrative units, such as Student Psychological Services, the Office for Students with Disabilities, and the Office of Residential Life; student pre-medical or health-related societies or clubs; and branches of undergraduate and graduate student governments. SHAC liaisons were responsible for establishing contacts, attending meetings, and remaining in communication throughout the academic year with these groups. The liaison positions not only provided a mechanism for SHAC to gain increased visibility on campus, they also enhanced SHAC's effectiveness in meeting our objectives by strengthening coalitions with groups working to improve campus health and well-being. Two such examples – SHAC's experience with Student Psychological Services and with a subset of law students – are discussed below.

SHAC's Role in Student Mental Health Services

Possibly one of the most substantial changes in SHAC policy and programming made in the past few years is the increased attention SHAC has given to mental health services at UCLA, specifically those provided through Student Psychological Services (SPS). While SHAC received some student feedback about SPS, the impetus to focus on developing SHAC's relationship with SPS came largely from SHAC members who had personal interests and experiences with mental health services and from reaction to a University of California *to SHAC's mission, in recent years, SHAC has prioritized developing the health and wellbeing."*

(UC) wide report on the state of mental health services on its campuses. This initial interest was reinforced following the tragic, and highly publicized, 2007 shootings at Virginia Tech, which increased national attention to the importance of outreach and prevention in university mental health services.[5] SHAC created a subcommittee to develop a working relationship with the SPS Director and staff, a relationship that proved particularly productive since the SPS Director welcomed student involvement and openly shared utilization data with SHAC representatives. Specifically, the SPS Director was concerned about the impacts funding shortfalls had on wait times for intake and follow-up appointments for psychotherapy visits, and was interested in SHAC's feedback on how best to respond to these problems. After reviewing utilization data and receiving numerous complaints from students about long waits for SPS visits, SHAC moved to advocate for increased funding for mental health services at UCLA. This advocacy – combined with increased attention given to mental health services across the UC system – was successful, resulting in additional University resources directed towards SPS staffing and services. These changes resulted in decreased wait times for intakes for both psychotherapy and psychiatry services at SPS.

SHAC and Campus Outreach

An example of how SHAC's increased visibility on campus resulted in engagement with an emergent health care access issue is illustrated through SHAC's work with students in the UCLA Masters of Law (LL.M) program. Having heard about SHAC through other law students, representatives of the LL.M contacted SHAC about their difficulty obtaining health insurance. Specifically, because of their provisional (non-student) status at UCLA, LL.M students were not eligible for University services, including health services provided through the Ashe Center. While the LL.M students were not able to achieve desired results from campus administration, some of these same administrators were accustomed to working with SHAC and valued the opinions of SHAC members. As a result, a SHAC representative working on the LL.M issue was able to balance the concerns of administration and students and work with both parties to arrive at an acceptable resolution. The result of these discussions was that LL.M students were provided the option of individually purchasing the Student Health Insurance Plan and thus gaining access to health care services at the Ashe Center while attending UCLA.

Additional Campus Outreach

In addition to the implementation of liaison positions, SHAC instituted other measures to improve its visibility on campus and enhance its overall effectiveness. For example, SHAC developed a relationship with reporters at the UCLA student newspaper – the *Daily Bruin* – in order to foster coverage of health-related issues and to respond to emergent ones. One such issue was the need to raise student awareness about federal changes in Medicaid policy that impacted the reimbursement of contraceptive services at university health centers. A *Daily Bruin* reporter contacted SHAC and conducted an informative interview with a SHAC member as part of her coverage of this issue. SHAC also worked with the Ashe Center to design appropriate and timely advertisements in the *Daily Bruin* (paid for by the Ashe Center) on issues related to student health and wellness. The ads highlighted services available at the Ashe Center, such as the availability of flu shots during Fall-Winter quarters, and further raised SHAC visibility on campus.

Besides use of the *Daily Bruin*, SHAC increased its presence on campus by other means. SHAC attended health fairs, such as those conducted for student orientation week, mental health awareness, and World AIDS Day. Having a table of information available at these health fairs allowed SHAC representatives the opportunity to talk to students about their concerns and to raise awareness about SHAC and student health issues in general. SHAC also worked to increase awareness of the SHAC e-mail and voicemail mechanisms for obtaining student feedback on their experiences at the Ashe Center. By placing stacks of SHAC business cards and flyers (with the e-mail and voicemail information clearly indicated) at strategic locations around campus, such as the waiting rooms of student services offices or academic departments, SHAC further increased its visibility on campus. This outreach resulted in increased e-mails and voicemails received from students asking questions related to their insurance coverage, clinical services, or prescription drug benefits, among other inquiries to which SHAC members responded in a timely manner.

All of these outreach activities not only strengthened SHAC's visibility among UCLA students, but also enhanced University administrators' respect for SHAC. As a result, administrators solicited SHAC feedback in the past year on a range of issues relating to overall student health and wellbeing. One such issue was the restructuring of the Student Affairs Division in order to better organize programs related to student health. The UCLA Vice Chancellor of Student Affairs presented SHAC with a plan for administrative restructuring and attended carefully to SHAC's input on how to streamline programs and services to best meet student health needs. SHAC feedback was also solicited by several UCLA faculty members who were interested in designing a course for undergraduate students with an interest in public health. The course was based on the principles of *Healthy Campus 2010*[6] and designed to teach the basics of community health program design, implementation, and evaluation. SHAC members reviewed draft course syllabi, provided insights based on their experience as student health advocates, and lobbied the School of Public Health to include the course in its undergraduate curriculum. According to Pam Viele, Director of UCLA Health Education and former SHAC administrative advisor, partnership with SHAC is valuable because, "SHAC has credibility in the world of administrators and of students. This unique positioning allows SHAC to engage in a 'shuttle diplomacy' of sorts that promotes understanding …between groups that do not necessarily share a common 'culture'."

SHAC's Role with Student Health Insurance

UCLA's decision to change insurance providers during the 2006-2007 academic year offers a prime example of how the University relies on SHAC to provide representation of its student population during a major change in a campus health care policy. As members of the Student Health Insurance Committee (SHIC), SHAC representatives were charged with not simply representing their own personal interests, but with thinking about the needs of present and future undergraduate and graduate students. Hilary Howard, a current graduate student member of SHAC, describes the challenge of representing UCLA students through SHIC: "It is important to consider the good of the group rather than the concerns of particular individuals, especially since SHAC represents the welfare of over 30,000 students." Some issues are important to all students, such as cost and quality of care, while other issues are particular to a subset of students, such as dependent coverage and GAP coverage for graduating students. By voicing students' concerns to the administrative and clinical representatives on SHIC, SHAC members helped guide the decision-making process and ultimately the selection of a new insurance provider supported by both students and campus officials.

Including students in the insurance renewal process presents both benefits and challenges to all parties involved. The University benefits from student representation in the renewal process because students lend credibility to the process, help build buy-in to plan changes, and assist with the transition to new policies and procedures. Students also know what they need from a health insurance plan and help ensure the plan meets the student body's needs. According to Susan Quillan, Chief of Clinical Services at the Ashe Center and SHAC advisor, SHAC's participation in the health insurance negotiations is beneficial because: "Only students can hope to know what students want among the tradeoffs that inevitably have to be made. Students who participate can then effectively educate many other students and help explain the way the process works." There are many challenges to student involvement as well. It is important to clarify students' roles and responsibilities in relation to the decision-making process. For this reason, last year, the UCLA SHAC worked with SHIC to develop a set of written policies and procedures for the renewal process (which had not previously existed). Additionally, information asymmetry will always exist between student-consumers, administrative staff, and clinical providers. Addressing this gap is important so students can play a meaningful role in the negotiation process.

The Expansion of SHAC at UCLA

As a result of the increased attention paid to outreach to various campus entities, student groups, and *that to effectively promote student health, it must expand its purview and on overall wellbeing in the campus community."*

University administrators, SHAC came to realize that its mission should specifically articulate its expanded role in overall student health and wellbeing at UCLA. When SHAC was established in 1972, its mandate was to oversee health services provided at the Student Health Center (as mentioned above). Over the years, and particularly because of increased outreach and enhanced relationships with a broader spectrum of health-related entities, SHAC began to view this focus as too narrow. As a result, SHAC initiated a process of modifying its charter and bylaws to reflect a broader mission. In 2006, the following, revised, mission statement was adopted by SHAC and approved by both undergraduate and graduate student governments:

As the officially recognized UCLA student committee charged with having oversight and input into the provision of health services as well as with fostering the overall health and wellbeing of UCLA students, SHAC has established formal relationships not only with the Ashe Center, but also with other administrative bodies associated with student health and wellness. These programs include, but are not limited to: the Ashe Center, the Center for Women and Men (CWM), the Office for Students with Disabilities (OSD), and Student Psychological Services (SPS). The mission of SHAC is to ensure that the Ashe Center promotes and provides high quality efficient and cost-effective health care for UCLA students, and that other UCLA programs provide needed physical and mental health services and other services needed to foster student wellbeing.

This revised mission clearly articulates a change in vision about SHAC's role at UCLA. While oversight of student health services (their clinical provision and administration) remains important, SHAC recognizes that to effectively promote student health, it must expand its purview and continue to strengthen its working relationships with other campus entities focused on overall wellbeing in the campus community.

SHAC has also made changes to its internal organizational structure in response to its expanded purview and in order to continue to represent the UCLA student body effectively. For example, while the expected term for a SHAC representative was two years, many appointees served only one year due to graduation. To counter this problem and increase SHAC continuity of members, SHAC lobbied undergraduate and graduate student governments to appoint students who were available to serve the full two-year term. Additionally, SHAC worked to convince student governments about the importance of having SHAC members serve over the summer months, due to the significant amount of work that could be accomplished during this time. The governments agreed, and current appointments are for terms that allow for summer coverage.

SHAC has also considered other mechanisms that will help it better represent the UCLA student body in the years to come. One idea was to conduct focus groups with undergraduate and graduate students prior to the renewal of the health insurance plan. This process would allow for students to voice their likes and dislikes about the current system and to provide SHAC members with additional information to bring to the negotiating table as members of SHIC. As part of the UC system, SHAC has considered setting up an annual meeting and/or website with other UC SHAC equivalents to discuss and share issues faced by students on all campuses. In addition, members of the UCLA SHAC attended the American College Health Association (ACHA) conference and were able to share ideas with SHACs from across the country. This participation, supported financially by the Ashe Center, is something SHAC would like to continue in the years to come.

Conclusion

The evolution of the UCLA SHAC has made evident the benefit of actively including students while adapting to the ever-changing university health care environment. Reaching out to students is no simple task and multiple, complementary approaches are necessary to connect with a broad range of students and administrative entities. Collectively, these efforts can best capture the needs of the student body and help universities adapt to meet present and future challenges.

Student leadership, not simply participation, in the oversight of services that promote student health and wellbeing profoundly benefits the university. By engaging students in this process, campus administrators develop a valuable relationship with the student body. A group like SHAC becomes a conduit to the students' likes and dislikes of the current system. The trust that evolves

"The evolution of the UCLA SHAC has made evident the benefit of actively including students while adapting to the ever-changing university health care environment. Reaching out to students is no simple task and multiple, complementary approaches are necessary to connect with a broad range of students and administrative entities."

between students, administrators, and service providers serves as a key component to effectively adapt to the continually changing health care landscape. Dr. JoAnn Dawson, Interim Director of the Ashe Center, sees multiple benefits to student involvement through her experience serving on SHIC. She explains, "The process educates energetic community-minded students who will be better informed health consumers, citizens, and perhaps even develop career aspirations." Ultimately, the process is cyclical – the more universities offer students opportunities to engage in meaningful ways, the more students' feedback can enhance overall campus health and wellbeing.

While we have focused on the UCLA experience as a case study of student involvement in campus health-related programs, it is important to emphasize that we offer this example as one among many possible directions student involvement in university health programs may take. Challenges to achieving high levels of student involvement may emerge when enrollment in campus health insurance is voluntary and there is less incentive for students to get involved in the oversight of health services. On the other hand, in large public universities like UCLA where insurance is mandatory, students are working alongside administrators and other stakeholders to advocate for public policies that would institute universal health care access across the state college and university system.*

In conclusion, by sharing our experience as student health leaders at UCLA, our intention has been to spark further discussion of creative ways to increase student involvement in campus health programming, with the overall goal of improving the quality and efficiency of health services and the overall quality of life for campus communities.

Burton O. Cowgill, PhD, MPH, is a recent graduate from the UCLA Department of Health Services in the School of Public Health. Burton currently works as a project director at the UCLA/RAND Center for Adolescent Health Promotion – a Centers for Disease Control and Prevention (CDC) funded prevention resource center. His current efforts focus on addressing childhood obesity, studying families who have an HIV-positive parent, and evaluating public awareness of the recent California Paid Family Medical Leave legislation. He has also worked for the Centers for Medicare and Medicaid Services (CMS) as a health insurance specialist and as a fellow for Senator Edward Kennedy on the State Children's Health Insurance Program (SCHIP) legislation. Burton was a member of the UCLA SHAC from 2004-2007 and served as the graduate student co-chairman for over 2 years. He can be reached at bcowgill@ucla.edu.

Kristin Elizabeth Yarris, MPH, MA is a PhD student in the UCLA Department of Anthropology specializing in Medical Anthropology. Kristin works as a graduate student researcher with the UCLA Sloan Center for the Everyday Lives of Families. She has several years' professional experience working with non-profit organizations on issues related to community organizing and development for health. Her graduate studies have focused on family health and mental health in Latin American and U.S. Latino communities. Kristin was a graduate student member of the UCLA SHAC from 2005-2007. She can be reached at keyarris@ucla.edu.

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* Such an experience was shared with us during our 2007 ACHA presentation, when representatives of Oregon state colleges and universities informed us of their advocacy work in this direction.

BGSU's LEAN Program

Glenn Egelman, MD, Barbara A. Hoffman, MSN, CNP, and Richard Sipp, MBA, Bowling Green State University

Editor's Note: *During the Leadership Forum, Dr. Glenn Egelman spoke of their use of the "LEAN" approach to improving the efficiency of their operations at Bowling Green. This brief article describes what they did and the results they achieved. The reader may ask, what exactly is the "LEAN" approach? The concept derives from the fairly long-standing methodology of process reengineering, with strong emphasis on the use of the people involved in the work, with respect for their insights and and contributions. At Bowling Green, there were also assurances that this would not result in layoffs, although particular jobs might well be redesigned. The LEAN Process also puts heavy emphasis on the customer experience as the starting point, with the two core questions: "How do we make that better for the customer?" and "How do we deliver that improved experience more efficiently?" Both process reengineering discipline and its 'disciple', the LEAN approach, rely on a thorough analysis of every component of the workflow. In most institutions, problems are solved with a timely "patch" or "work-around" fix. Over time, these become an embedded part of the work process, small, insidious inefficient detours around institutional potholes. The LEAN process identifies these without blame, unwinds them and fills the pothole, or sometimes cuts an alternative route to a better customer experience.*

Just a few months ago, the terms "LEAN healthcare" and "LEAN higher education" were not familiar to the 60 employees of the Bowling Green State University Student Health Service (SHS). Because the terminology could imply the loss of jobs, there was, understandably, some significant concern. So all employees of the SHS were reassured that this was not a way to reduce people – in fact, LEAN was a way to make our work lives better, more efficient, and more customer service friendly. We did not anticipate how once you learned the LEAN process, you began to look at many things in a very different, process-oriented fashion.

Bowling Green State University is a public institution in Northwest Ohio that enrolls about 21,000 students. The Student Health Service resides within the Division of Student Affairs and is a complex organization which includes a pharmacy, laboratory, business office, insurance office and an acclaimed health promotions unit, in addition to our busy outpatient medical services. Total visits by students to the medical units of the Student Health Service totaled 36,994 for the 2006-07 year.

In the spring of 2007, the leadership team of the Student Health Service met with the leadership of Student Affairs and three faculty members with an interest in a LEAN process re-design to kick off our "LEAN" process evaluation. We are fortunate that two of the faculty members have written on LEAN in higher education, while one has significant consulting experience with LEAN in health care.

Our project involved applying LEAN techniques to the processes in the Student Health Service with the

TABLE 1

objectives being improved patient flow, reduction of waste, and elimination of non-value added work. The Student Health Service and Student Affairs teams followed these principles of LEAN Higher Education:

- Define the values of the process from the perspective of the person who receives or benefits from the process
- Identify the flow of the process, from both the consumption and provision perspectives, to determine whether and how each step in the process contributes value
- Eliminate the many types of waste that add no value to the process
- Make the process flow smoothly, with activities or services "pulled" as needed by the consumer rather than "pushed" by the provider
- Pursue perfection through a combination of continuous improvement and radical transformation of the process

The process followed in the Student Health Service is captured in *Table 1* on the previous page.

Outcome

There were many benefits derived from the LEAN process as undertaken at the Bowling Green State University Student Health Service:

- 94% of the staff of the Student Health Service were involved on the initial teams or on the task forces that followed.
- As a result of involvement, there is a heightened awareness of the process of patient care from the patient's perspective and of the roles the various departments play in the process.
- No jobs were lost or positions abolished.
- Many specific improvements were made, including, but not limited to, the following:
  - A standardized stocking system of exam rooms and inventory lists was implemented
  - The triage nurse now handles insurance pre-certifications and Emergency Room follow-ups
  - Scheduling changes were made
  - Nursing assessments were implemented
  - A pharmacy computer checking station was created to verify accuracy when filling prescriptions
  - Standardization of equipment for all rooms/offices was implemented
  - The interior way-finding and signage was upgraded
  - The waiting area outside pharmacy and lab was modified to enhance confidentiality
  - Provider profiles were included in a marketing campaign
  - New marketing displays for use in Orientation and Registration and throughout campus were created
- The following improvements are in process:
  - We are examining sign designs and needs now and for a new health center building
  - A pager system for Pharmacy patients is begin investigated
  - Self-check-in is being implemented
  - Standardized terminology is being used
  - Our "Best Practices" initiative is being expanded
  - Patient work-ups are being standarized and streamlined
  - We are creating electronic access to educational materials via a shared drive system
  - Quality control and standardization of bulletin board displays is being started
  - Work areas in the Pharmacy and Lab are being rearranged for efficiency

We believe that there has been a significant benefit gained from involving the staff in the LEAN project. In a recent survey of the SHS staff, 81% said that they have witnessed changes within the clinic as a result of the LEAN process and believed LEAN to be a "positive experience." As one staff member noted, "It was a great experience and reason to ask ourselves 'Why do we do it that way?' Is it simply because that is the way it has always been done and have we ever thought how we could improve that aspect of our day or the patient's day?"

The LEAN process will continue to be utilized in our current facility and will be a major design component in the creation of our new Health Center Building – the construction of which is slated to begin this semester.

our work lives better, more efficient, and more customer service friendly. We many things in a very different, process-oriented fashion."

The LEAN process has built a firm foundation, not only in terms of improved patient flow and reduction of waste, but also in staff collaboration and camaraderie. In the words of one staff member, "It was a great opportunity to have time to spend with co-workers in other departments to get a real appreciation of what they do and work together to improve things for everyone. I think it will be a great asset for the layout of the new building."

Glenn Egelman, MD, is Director and Physician-In-Chief for Bowling Green State University. He has held the position of Director of the Student Health Service since 2004. He came to BGSU from Skidmore College in New York State where he was the Director of the Health Services. Before that, Dr. Egelman held clinical and teaching positions at SUNY Stony Brook and the University of Rochester, also in New York . He received his undergraduate degree from Colgate University and his medical degree from the University of Rochester School of Medicine, and is board certified in internal medicine. His interests include primary care medicine, the biopsychosocial model of health care, which recognizes the interplay of health and all aspects of one's life, travel medicine and healthcare management. Dr. Egelman has held several leadership positions in the American College Health Association and the New York State College Health Association. He is a Fellow of the American College of Physicians, and a member of the American College of Physician Executives and the Society of General Internal Medicine. He holds faculty appointments as an adjunct Associate Professor of Public Health and a Clinical Assistant Professor of Medicine. According to the Consumers' Research Council of America, Dr. Egelman is one of America's Top Physicians. He can be reached at egelmag@bgnet.bgsu.edu.

Barbara Hoffman, MSN, CNP, is Interim Associate Director for Clinical and Educational Services of the Student Health Service at Bowling Green State University. She earned her bachelor's degree in nursing at Capital University and her masters in nursing at Case Western Reserve University. She is a Women's Health Nurse Practitioner and a Sexual Assault Nurse Examiner (SANE). Barb has been at the University since 1985. She offers expertise in women's health, eating disorders and sexual assault. She can be reached at bahoffm@bgnet.bgsu.edu.

Richard Sipp, MBA, is Associate Director of Operations for Bowling Green State University. Dick came to Bowling Green from Medical University of Ohio where, over a twenty-five year span, he held many positions in hospital and college administration; the last one being Vice President of Operations. He has served as Chairman of the Board of the Hospital Council of Northwest Ohio, President of the Rotary Club of Perrysburg and President of Perrysburg Youth Soccer Association. In addition, Dick is an adjunct professor in the Business School at BGSU, having taught in the Health Care Administration program for over 15 years. He holds an MBA and a BS from the University of Florida. He can be reached at rsipp@bgnet.bgsu.edu.

Where To See Chickering Next

March 8-12	**NASPA national meeting** Chickering presenting Benefit Design Trends in Student Health Insurance and the Fundamentals of Underwriting
March 12-14	**Central College Health Association (CCHA)** Lawrence, KS
March 26-28	**Southern College Health Association (SCHA)** Savannah, GA
May 26-30	**National Association of International Educators Conference (NAFSA)** Washington, DC
June 3-7	**American College Health Association (ACHA)** Orlando, FL

Briefly Noted...

In reviewing the literature on change management, we thought it would be useful to look at four areas: public policy on health care and health insurance; changes over time in a specific student health program; communicating for change; and the outlook for changes in the health care delivery system and their implications for cost.

In the current political season, virtually all candidates are talking of change and focusing specifically on health care – its costs and access to insurance. Setting the theme of change in the health insurance industry, the Association of Health Insurance Plans (AHIP), in its daily electronic newsletter, ended its issue the other day with a quote from General John M. Shalikashvili, past Chairman of the Joint Chief's of Staff: "If you don't like change, you'll like irrelevance less." The message is clear. Health care in the U. S. is going to change, and to some degree, so will student health.

To put some framework around the current political and public policy debate, this past fall, Aetna released a document called 'Transforming health care in America," in which it laid out five beliefs. In summary they are:

1. Affordable access to health care that produces quality outcomes and facilitates prevention, wellness and care coordination;
2. The shared responsibility for transforming U.S. health care requires public and private sector leadership and collaboration;
3. Universal coverage is only possible when there is universal participation;
4. Comprehensive health care reform should be built upon the strength and successes associated with the competitive marketplace; and,
5. Consumers must be empowered with the information, technological tools and product options necessary to make prudent health care decisions.

Moving from the macro level of policy to the micro level of practice, on December 28, the *Wall Street Journal* ran a front page story on Cornell's comprehensive program to identify and help distressed students. Those of you who know the Cornell story or who read this article know that what the *Wall Street Journal* headlined as "Safety School – Bucking Privacy Concerns, Cornell Acts as a Watchdog," is not a recent change, but a process of continuous improvement that has gone on for years.

Indeed, in the Fall of 2001, *Spectrum* carried a detailed article by Dr. Timothy Marchell from Cornell on "Reaching Out to Students in Distress," part of the program that was reported in the *Wall Street Journal*.

Highlighting this ongoing change process, the *Journal* reported: "Dr. Corson-Rikert asked Dr. Marchell and others to build a network to train people to notice problems and give them ways to report them, while still respecting student privacy. An advisory council on mental health strategies made up of Cornell staff, faculty, and student leaders had its first meeting in early 2004, and members had a realization: In school post-mortems after tragedies, "each person knew pieces of the story but no one saw the whole picture," says Dr. Marchell. "If they had shared the information, maybe we could have intervened."

"Dr. Marchell spoke with several suicide-prevention organizations, who pointed the school to a surprising model; the Air Force."

And further, the *Journal* reported: "Cornell adapted parts of the program. Dr. Corson-Rikert enlisted the University's president, David J. Skorton, to use his speeches and articles to encourage everyone on campus to watch out for each other's mental health. Counselors began seminars to teach signs of emotional problems or addiction. Last spring, Cornell's Health Center began screening students who came in for any reason for signs of depression, asking them about trouble sleeping, poor appetite, difficulties concentrating of thoughts of self-harm."

We recommend the whole article to you as an example of an ongoing and successful change process. Many lessons suggested elsewhere in this issue are highlighted here. Consider these three:

1. There is no such thing as one change. Change begets change, some good and anticipated, some unanticipated which may be less desirable.
2. Broad scale change requires broad scale participation; thinking outside the box often means involving people who are outside the box (of your institutional "turf").
3. Change involves institutional politics and endorsements from various constituent groups will be essential. The Cornell story involved students, parents, staff, faculty, the president, and the community.

The Cornell program would never have achieved the results it has with the broad base of coordinated activities without excellent and ongoing communications. In 1996, Roger D'Aprix, a senior consultant at Mercer Human Resources Consulting, authored a small book entitled, *Communicating for Change, Connecting the Workplace to the Marketplace*. D'Aprix makes many useful suggestions, but here we only highlight three. In discussion of how to really focus on the market, D'Aprix makes the distinction between "Visionaries" and "Missionaries." Visionaries, he suggests, are "the people who look over the head of the crowd and see things the rest of us somehow miss." He goes on, "Generally they are able to express their vision in terms that engage the curiosity, the interest, and the imagination of the rest of us." In the Cornell story noted above, it would not be a stretch to describe Dr. Marchell as a visionary. The "missionaries" by contrast are the people "who are charged with the heavy lifting that converts a vision into something tangible." Organizations need both.

Second, D'Aprix's insight into what everyone in an organization wants and needs is elegant in its simplicity. He says everyone wants to know: "What is my job"; "How am I doing"; and "Does anyone care." The obvious corollary to this is that leaders must ensure that the organization is continuously answering those three questions.

The third insight we highlight is D'Aprix's discussion of empowerment. Starting with the marketplace, he comments, "Demanding customers want workers who are empowered to address their needs on the spot. They do not want to stay on hold…while someone gets permission." And, further he notes that the organization that empowers people:

- "Provides genuine opportunities for involvement.
- "Empowers people to take the initiative and make decisions without second guessing them.
- "Supports the risk takers even when they make a mistake.
- "Recognizes and rewards true contribution.
- "Encourages and supports cross-functional collaboration.
- "Promotes mutual trust."

Going back to the Cornell story, there clearly has been a strategy to empower a broad range of people on campus to be concerned about students' well being.

Finally, to the question raised at the Leadership Forum about where health costs may be going, the current issue of *Health Affairs* has an article by Paul Ginsburg entitled, "Don't Break Out the Champagne: Continued Slowing of Health Care Spending Growth Unlikely to Last." To highlight several of Ginsburg's arguments:

- **Physician activity**: More entrepreneurial physicians have recognized the opportunity for particularly high returns from facility, as opposed to professional payments for procedures such as imaging, endoscopies.
- **Medical arms race**: With the loosening of managed care restrictions, the medical arms race has resurfaced…. But whether supply is inducing or responding to demand, building booms lead to more spending on health services.
- **Self-referral incentives**: Today, as more physicians have increased financial stake in the provision of services, self-referral incentives apply to a much larger portion of health care spending than in the past. The literature on self-referral incentives is very clear, showing much higher referral rates for procedures when physicians have an ownership stake in facilities.
- **One other macro factor:** Research by the CMS national Health Expenditures group and by outside economists and actuaries has established the role of the economic cycle in health spending trends. A portion of the slowing in trends over the past few years may in fact be the lagged impact of the 2001 recession, indicating that the impact of the recent years of economic recovery and rapid growth on health spending trends is likely to be ahead of us. This cycle has often led to difficult periods for those who pay for health care, when general economic distress and rapid increases in health care spending coincide.

So managing change in student health requires attention to public policy, to best practices among peers, to the literature on change leadership, and to economic and systems research.

Notes:

1. D'Aprix, Roger, *Communication for Change; Connecting the Workplace with the Marketplace*, Jossey-Bass Inc., 1996.

2. Ginsburg, Paul B., "Don't Break Out the Champagne: Continued Slowing of Health Care Spending Growth Unlikely to Last." *Health Affairs*, January/February 2008, Vol 27 No 1, pp 30-32.

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One Charles Park
Cambridge, Massachusetts 02142-1254
(617) 218-8400
(617) 218-5700 fax

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