

FINAL DRAFT

05-15-06

I. CPR Overview

On November 14, 2005, Helen Mamarchev, Ph.D., Vice President for Student Affairs (VPSA) at Illinois State University invited J. Robert Wirag, HSD to serve as the External Consultant/Reviewer for the Student Health Service's (SHS) Comprehensive Program Review (CPR). Scott Champaign was identified to serve as the consultant for Student Health Insurance. A Site Review Team (SRT) of five additional individuals was confirmed in addition to the external consultants who served as Chair and Co-Chair of the SRT. Team members:

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The CPR for the SHS program was conducted over a three day period, April 10-12, 2006 and represented the seventh of a total of eight reviews conducted for

each department in the Division of Student Affairs. The purposes and values of the review are well documented in the “Comprehensive Program Review Manual” used by Student Affairs officials...namely “...to improve departments and programs and identify opportunities for future development.”

The internal CPR for the SHS program began in the summer of 2005 with a Self-Study/Self-assessment by the SHS and Student Insurance Office staff spanning the three-year period July 1, 2002 through June 30, 2005. The internal included input from every member of the SHS staff and was compiled by a core group of SHS representatives in a well-organized format for transmittal to the SRT members several weeks prior to the site visit.

The SHS staff deserves the highest commendation for the painstaking attention to the detail provided in their CPR Self-Study report. The report reflects an honest, straight-forward, easy-to-understand self-assessment that addressed the multi-faceted issues inherent in a complex organization. There was no apparent attempt to sugar-coat by over-emphasizing the program’s strengths in order to mask the opportunities for change. In fact, the many recommendations posited in their report hold great promise for the program’s future. Serious consideration should be given to those that are attainable given the various needs and availability of resources. Throughout this report, recommendations in *italics* as noted with an asterisk (*) identify those recommendations from the Self-Study that SRT members’ feel have special merit.

Members of the SRT met with many individuals representing faculty, students and staff vis-à-vis an ambitious three day schedule. In the process, Team members had the opportunity to hear first-hand a variety of comments...facts from some, perceptions from others. The challenge for Team members was to listen attentively, relate the direct comments to those in the voluminous CPR Self-study report and maintain a focus on program enhancement that respects the reality of a changing academy and healthcare industry.

Readers Choice. Given the length of this report, the casual reader may want to read through section II, a digest of the salient features gleaned from the CPR Self-Study and the SRT interviews during the site visit. This digest is intended to whet the reader’s interest in learning more about the program and suggestions for program enhancement. Section III is intended to facilitate the strategic planning process conducted by SHS staff this coming year. This more inclusive section includes consultative comments, commendations, findings and recommendations. The four themes that emerged during the course of the SRT review are featured in both Section II and III.

A. Role of the Campus Health Service Program

College health programs have a simple and clear mission: “to advance the health of students.” This can be accomplished by promoting a healthy community that supports the academic mission of the university.

B. Best Practices

“Best practices” for ambulatory college health services can be found in a variety of sources. Two nationally accrediting organizations used by college health officials include the Accreditation Association for Ambulatory Health Care (AAAHC) and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). These organizations apply standards of quality to determine if a program “measures up”. Also, various disciplines of medicine, especially in the Board specialties, publish best practice protocols that are science-based. The American College Health Association (ACHA) is another excellent source, in particular its *Guidelines for a College Health Program*. The following values were taken from these *Guidelines* because they give direction to college health workers. And, they constitute the foundation for the Team members who prepared this report.

1. A college health program should provide a wide spectrum of services, which will support the “health” of the campus community in its broadest sense. This means a commitment to integrating primary prevention and public health services, as well as clinical and mental health services.
2. All students should have easy and equal access to services regardless of their income level or ability to pay. This related to another value, which is that services should be available regardless of race, sex, nationality, sexual orientation, age, religion, or gender. A college health program should be actively involved in the diverse communities on campus.
3. The college health program should be the principal advocate for a healthy campus community. This may be realized by taking the lead on policy issues such as public safety, excessive alcohol use, tobacco use, etc. This also means maintaining a database of health behaviors and population-specific risks.
4. The college health program should provide quality service. National accreditation of specific services, where available, can provide guidance in this area.
5. Students should have a significant voice in advising on the breadth and depth of a college health program’s mission, goals, services, and programmatic evaluation.

II. Report Digest

The questions below were derived by SRT members from the CPR Self-Study documents provided prior to the site-visit. Four broad categories are identified. Answers by Team members were generated in the course of the three-day site visit and reflect the input from the diversity of backgrounds and experiences of Team members.

The four categories are: (1) program – scope of services, (2) staffing, (3) financing and (4) facilities and technology.

A. Program – Scope of Services

1. Q. Is the program meeting the needs of those eligible for services?
A.
 - a. Although the SHS is promoted as providing “comprehensive” care, it is not.
 - b. The most glaring void given ISU’s size is rehabilitation services for all students, coordinated with Athletic Training services available for athletes elsewhere on campus.
 - c. Internal user survey results point to high satisfaction with services. And, earlier in the year arrangements were made with an ISU marketing professor to administer a campus-wide survey to obtain information about both users and non-users. Plans are underway to use the results of the survey to develop a marketing plan to promote the program and encourage students to use the many services offered when they want or need them.
 - d. Providers do a good job with episodic care, but there is no overall plan for chronic disease management.
 - e. Because health service staff is on an academic campus, they have opportunities for research and publication that is not encouraged as much as it could be.
 - f. Dedicated blocks of providers’ schedules should be reserved for students wanting to schedule their own appointments at times convenient to their class schedule.
 - g. Monitor security features of future technology to enable providers and patients to communicate via email.
 - h. See consultative comments, Section III, Scope/Program of Services, p. 11.

2. Q. What are the program elements that need additional resources?
A.
 - a. Improve communications with more emphasis on staff and leadership development.

- b. Reconfigure clinic space to facilitate patient flow and promote “care” teams;
 - c. Engage in programming outside the SHS facility to more fully integrate with the campus community.
 - d. Computer technology is available to enable providers to e-prescribe.
3. Q. Are there any services that can or should be reduced or eliminated?
- A. This could not be determined with certainty given the information provided. Consolidation of services such as business functions with the Student Insurance Office would better position the program to meet its fiscal challenges. Also, the lab, x-ray and pharmacy should be generating revenue sufficient to underwrite much, if not, all the costs of providing the service. Otherwise, future budget shortfalls will challenge the ability to provide the services or will encourage higher administration officials to consider outsourcing.
4. Q. How well is the scope of services communicated to students and parents?
- A. Communication needs improvement to remedy the confusion that exists by students concerning the health fee (what it covers) and the Health Insurance Plan premium (what it covers). The program would benefit by the successful execution of a marketing plan directed to faculty, staff, students, higher administration officials and parents.
5. Q. Why isn't the Counseling program administratively part of the overall campus health service program to promote the integration of physical health, mental health and health education?
- A. To date, a compelling argument has not been successfully accepted by higher administration officials to merge the programs under one umbrella into an all-encompassing campus health services program. The administrative structure is transparent to the students interviewed who understood SCS to be part of SHS.

B. STAFFING

1. Q. How adequate is the provider mix to meet the need?
- A. The goals of the organization should drive the mix of training and skills.
- a. An imbalance between physician and advanced nurse practitioner providers was recognized, as well as a gender concern with too few male providers.
 - b. The addition of a staff psychiatrist would enable the program to address increasing demands for mental health services.
 - c. There's a need to evaluate how licensed personnel are being used.
 - d. RNs should be more active in health education/patient education.

- e. The classification of advanced nurse practitioners as civil service personnel infers a less than professional status compared to physicians and health educators.
2. Q. Are the providers and support staff members skill sets sufficient to manage the demand for the various clinical presentations?
- A.
- a. As a group, providers should adopt best practice protocols, including phone protocols.
 - b. Clarification should be provided to both advanced nurse practitioners and registered nurses concerning clinical duties/privileges to maximize the value of their training, skills and experiences.
 - c. Providers should be trained to do coding as a prelude to billing for services in order to improve the fiscal viability of the program.
 - d. “Care Teams” should be arranged to foster teamwork among the various care givers.
3. Q. How flexible, fluid and accommodating are providers to meet patients’ fluctuating demand for services throughout the day?
- A.
- a. The presence of a clinic manager to address concerns of sweat-equity among providers and support staff as patient demands fluctuate during the day would encourage a more cooperative staffing environment.
 - b. Development of care teams to manage patients will build camaraderie and empower providers.
 - c. Providers are quite reluctant to be more flexible with their schedules and are resistant to evening and weekend hours.
4. Q. Does provider location within the facility promote patient flow from point of entry to egress?
- A. The current physical environment is not conducive to efficient patient flow.
- a. Too much space is dedicated to waiting areas. Patients should be moved ASAP to the “point of care” by providers with adequate nursing support.
 - b. Patient care efficiencies can be achieved by reconfiguring current space, providing at least two exam rooms per provider, and equipping providers with portable (laptop, tablet) computers to provide real-time data entry during a gradual transition to a computerized system that facilitates billing and record keeping with an electronic health record.

5. Q. What are the incentives that attract and retain the health care workers?
- A.
- a. Working with the student age group. (Staff satisfaction high)
 - b. Working hours. ((Staff satisfaction high)
 - c. Feelings of empowerment, teamwork, and support for professional development. (Room for improvement was expressed by staff)
 - d. Classification equity. (Reclassifying advanced nurse practitioners from civil service to professional will improve morale and their sense of value.)
6. Q. How well prepared is the current staff to manage increasing numbers of students with chronic medical conditions that require on-going care?
- A. Paradoxically, developing a system to manage chronic conditions could provide the support to improve working conditions. Appropriate management of chronic conditions requires teamwork and systems to prompt providers; adherence to best practices; and focused health promotion and rehabilitation...a good place to start initiatives that result in interdisciplinary teamwork and better communication among team members.
7. Q. What additional staff, if any, should be added to better serve internal and external customers? What changes among current staff are advisable?
- A.
- a. Hire a coder and arrange for additional continuing education for providers regarding accurate coding to support a billing and claims filing process that minimizes errors, saves time and provides for timely reimbursement.
 - b. Develop in-house “experts” in areas like dermatology and orthopedics to minimize outside referrals.
 - c. For the overall program, consider expanding the leadership scope by expanding the Director title to either Executive Director or Assistant Vice President for Campus Health Services (AVP-CHS), with the Medical Director and SHS Administration Director, SCS Director, Disability Concerns Director and Health Promotions Director on a direct line report and include the Executive Director (or AVP-CHS) as an integral part of the Vice President for Student Affairs (VPSA) executive leadership team. Doing so will make a statement of value of campus health services to the greater community, over which the office of the VPSA has considerable influence.

C. FINANCING AND INSURANCE

1. Q. What cogent argument can be presented to change the present funding model to assure greater fiscal viability of the program without increasing students' costs for prevention and acute care services?
 - A. The preferred model for ISU is one that encompasses the essential elements of a campus health program because of the inter-relationships of clinical/medical services, mental health and health promotion/disease prevention. The preferred funding model is one that combines a pre-paid health fee required of all students carrying a specified number of credit hours, along with charging for specialty and diagnostic support services (especially those services that are typically reimbursable vis-à-vis insurance benefits). (See Section III, Financing and Insurance, p. 22 for more discussion.)

2. Q. Can a uniform health fee be assessed that is fair and equitable for students' considered eligible for services?
 - A. While it could be argued that the current health fee is fair and equitable for the services provided, it's an institution-by-institution decision whether to charge the fee according to the number of credits being carried each semester or by a uniform health fee charged each student carrying a threshold number of credits or more. The argument for adopting the latter is one of equal access, with the student carrying nine hours having just as ready access to services as the student carrying a full load of 12 hours or more. In this scenario, if the health fee is titrated according to the number of credits per semester, students carrying more hours are underwriting the costs of students carrying fewer credits who are eligible for the same services. The pros and cons must be weighed to ascertain the most desirable method of funding, along with further defining the services the campus health services should be providing.

3. Q. What "entitlements" should the health fee provide?
 - A. The health fee should entitle the student to unlimited access to the services without a visit fee (eliminates the financial barrier to access). And, the fee should entitle the student to diagnostic support services and defined clinical procedures for which there is a charge but at rates lower than those in the community. (See p. 24 for more discussion on setting charges for services.)

4. Q. Should fees for various services (lab tests, x-rays, pharmaceuticals, clinical procedures) be set at or below community rates in order to take advantage of students' medical insurance benefits?
 - A. Yes. (See p. 24 for more discussion on setting charges for services.)

5. Q. What additional revenue generating services should be considered?
 - A. Depending on the availability of space and patient demand/need (to be further defined), additional revenue generating services could include visit charges for specialty care services (Orthopedic Clinic, Psychiatry, Dermatology Clinic, OB/GYN with Board-certified specialists), optometric/vision care services, oral hygiene (dental hygienists) services, and rehabilitation services with a licensed physical therapist who charges for various modalities.

6. Q. What capital improvements to the program or facility will require special funding?
 - A. Additional services such as those identified above, plus psychiatry services, will require additional funding. And, renovations to reconfigure clinic space to facilitate patient flow, promote efficiency and productivity and to “repackage” the overall program of services to include SCS, Disability Concerns, expanded Pharmacy space and rehabilitation services will require an infusion of additional financial support.

7. Q. What business practices should be added to assure fiscal accountability and maximize the revenue potential of the program?
 - A.
 - a. Involve departmental supervisors as active participants in the annual budget preparation process and as key staff who share in the fiduciary responsibility for their part of the overall budget.
 - b. Add an experienced coder to facilitate billing for chargeable services reimbursable by insurance.
 - c. Maximize the billing applications of the current practice management system (PyraMED).
 - d. Combine business affairs with the Student Insurance Office.
 - e. Refine the chart of accounts to accurately track all revenue and expenditures associated with accounts payable and receivable.
 - f. Apply sound business practices to assure the fiscal viability of the program with a reserve balance that grows to three or four months of operations expenses.

D. FACILITY/TECHNOLOGY

1. Q. Other than aesthetics, what functional/structural changes should be considered to better serve users? If additional space is required to provide more services, what adjustments to the current facility would be necessary or feasible? (i.e. relocation of non-SHS offices/services) Estimated cost?
 - A.

- a. Obtain the services of a consultant with expertise in ambulatory care facilities planning and design to assess space needs given present and future demands and factor in projected changes to the present matrix of services.
 - b. Health Stop occupies prime real estate at the point of entry. While there is value in its location, its relatively low utilization raises questions about relocating the office and reconfiguring the space to better accommodate the changing business functions of the program in order to facilitate patient care services involving insurance and business-related activity during patients point of entry and egress.
 - c. Use existing space to cluster acute care, observation and “extended services” such as allergy injections, immunizations and travel counseling.
 - d. Re-examine preferred contiguous relationships of various services as a prelude to any rearrangement of space and functions.
2. Q. Given the rapid advances in technology in the health care industry designed to increase security, privacy, safety and accuracy, reduce liability concerns and expedite access to patient data, what are the new applications that should be considered and what is the proposed timeframe for implementation?
- A. Be patient with the PyraMED computerized practice management system purchased several years ago. It has far more functionality than is currently used and is adequate for any increase in billing activity. Also, the PyraMED product is evolving with elements of the EHR (electronic health record) that will enable staff to gradually move to a paperless medical record system. This EHR-“lite” approach is preferred over the costly proposition of buying a stand-alone EHR system and interfacing it with PyraMED.

Resistance to transitioning to an EHR can be anticipated by providers used to a paper record system. Gradually, however, the following EHR advantages are understood and new skills are learned: accuracy and timeliness of clinical information are ensured; redundant entries are avoided, thereby enhancing productivity; data is available instantly to all caregivers; and, guidelines and protocols are instantly accessible, as are medical knowledgebases and clinical decision support systems to facilitate best practices.

The SHS program is in a catch-up period with the greater healthcare industry in terms of other technology applications current used. For example, the migration from plain film to digital radiography, installing a computerized laboratory information system and using a clearinghouse to electronically process/adjudicate claims should

happen within the next two to three years to remain competitive with the changing marketplace.

3. Q. Is tech support adequate to meet the emerging needs of the program?
 - A. It appears so given the current demands for technical and applications assistance. However, as the need for additional technology increases, make or buy decisions will have to be made regarding tech support. More staff may be needed to assist with new computer hardware/software/interfaces for new applications as noted above to help manage the development of RFPs, selection of vendors, manage installations, conduct or arrange for staff training, run reports requested by administrative staff, manage upgrades and trouble-shoot as necessary with desk-top support requested by staff.

III. Prelude to Strategic Planning

The following section features a more detailed outcome of the CPR on-site review that is intended to help SHS staff with any transformation in thinking and planning for the program's future. The comments and recommendations are intended to reflect not only the current status of programs and services but also to posit changes that can and should be made in the context of a changing academy and healthcare industry. Consider the following section as "food for thought" for the pending strategic planning process by SHS staff in the ensuing year.

A. Scope – Program of Services

Consultative comments: If you've seen one campus health service... you've seen ONE campus' college health program, nothing more! SHS programs are all different because of the many variables that must be factored into the program's structure and function, including: campus location (rural vs. urban) and proximity to off-campus clinical resources; number of students living on- vs off-campus; age of the student population given the mix of undergraduates, graduate students and post-docs; socio-economic status and adequacy of medical insurance enrollment; individuals eligible for care (students only, students and spouses, child dependents, faculty and staff); means of financing (allocation, health fee, fee for service, or any combination); facility size and location; ability to compete with the healthcare market; philosophy and value placed on campus health services by higher administration officials; and the relationship of health to academic performance.

The scope of services for any campus health service program requires careful consideration because of its relationship to characteristics of the cohort to be served, staffing requirements, space requirements, and financing of services that make up the program. The notion of "basic services" is tied to those services that

should be provided to enhance health as it supports academic success and addresses health challenges young adults experience.

The challenges for higher administration officials and college health professionals in determining scope of services include:

- (1) knowing the health status of the student population served;
- (2) assessing students insurance status/needs as an effective means of protecting the institution's investment in its students and protecting students investment in their future;
- (3) assessing the availability and access to community services;
- (4) readiness to respond to public health threats, such as norovirus, SARS, pandemic flu or meningitis outbreaks; and
- (5) educating and treating students with regards to routine health issues, expediting referrals to higher-level care, and maintaining a state of readiness to respond to life-threatening situations such as suicide, alcohol poisoning, and sexual assault.

In a campus residential community, students' health needs will span the spectrum from prevention to clinical intervention/treatment to rehabilitation. It is recommended, therefore, that each aspect be addressed from (1) enhancing the health education component that focuses on student behavior; (2) tailoring-to-fit clinical services that respond to "most of the medical needs most of the students need most of the time" (services one would expect to receive from a primary care physician, a family doctor); and (3) the rehabilitation needs following musculo-skeletal injuries many students, especially student athletes, are likely to experience. Depending on demand, added value services such as specialty clinics (dermatology, orthopedic, OB/GYN) with part-time providers could be considered with fees-for services to underwrite the costs.

Perhaps the time is now for a more thorough assessment of wants, needs and the availability of resources to determine what ISU officials want the program to be in the foreseeable future. For example, one missing piece of the integrated campus health model for ISU is rehabilitation. Another is the administratively separate Student Counseling Service program.

The SHS program can not be all things to all people, and it is not cost-effective to provide services 24/7. Partnering with community organizations will pay healthy dividends, especially if partnerships in the form of preferred provider agreements (discounted services) are carved out with community agencies to reduce the high costs of specialty referrals, after-hours care for routine medical needs when the SHS is closed, and urgent or emergency care at the local hospital's Emergency Department.

Given the fact that approximately one-third of the student body turns over each year, an on-going public relations/outreach plan is essential in combating students' comments that they are not aware of the many services offered through

the SHS program. It is important for the SHS senior staff to be well connected with other campus leaders/decision-makers and encourage outreach activity by other staff. Opportunistic surveys of students who received SHS services as well as periodic (bi-annual) campus-wide surveys (e.g. stratified random sample of 10% of enrolled students) should be part of the plan to identify changing wants and needs of ISU students. Particular attention should be directed to student leaders, resident assistants, academic advisors, student affairs, and other staff, including faculty, who have frequent contact with students.

In order to provide quality clinical care, providers need access to diagnostic support services to support their clinical impression, render accurate diagnoses and prepare a treatment plan. To ISU's credit, clinical laboratory and x-ray services are provided on-site and provide for timely service to providers, convenience to patients and support of quality clinical care. Too often in college health the clinical laboratory is viewed as a profit center. That is marginally possible if charges for tests are at community rates. More often than not, following a cost-benefit analysis that factors in salaries and fringe benefits, calibration of equipment, test controls, competency testing, equipment amortization, maintenance costs, and costs of reagents and other supplies, costs exceed revenue. This is why the health fee is so essential. It enables the program to cover its operations costs for essential services. The health fee either provides lab tests at no charge (not recommended) or at rates lower than community rates (preferred).

COMMENDATION

SRT members acknowledge the excellent growth, development and recognition the current program has received, especially since the current facility opened in 1992. It is a real credit to the program to have been accredited at three-year intervals by the Accreditation Association for Ambulatory Health Care, Inc. since 1986. The most recent accreditation review was September 2005. This three year review is voluntary and enables SHS staff to demonstrate the quality of their services and performance against nationally recognized standards. Additionally, the laboratory is certified under the federally mandated Clinical Laboratory Improvement Amendments (CLIA) which requires compliance with quality standards. Facilitating this accreditation outcome is the SHS Quality Management and Improvement program that involves members of the Quality Improvement Coordinating Committee.

Programs that achieve accreditation recognition wear the "good housekeeping seal of approval", the gold standard for quality that says the program "measures up". The staff is to be commended for this achievement.

The SHS is in an easily accessible location; health services are clustered in one facility to facilitate access; and the over-all program is held in high regard

because of the leadership positions in college health organizations that various staff held the past 20 years or so.

Arrangements have been made to extend services to Lincoln College students. There is interest in accepting international students attending Heartland Community College. Perhaps consideration could be given to Illinois Wesleyan University students to have access to the ISU SHS as well. These goodwill gestures to share resources by ISU bodes well for strengthening community relations. Additionally, there is a positive collaborative relationship with SHS staff and staff at various community health agencies to facilitate access by students for discounted services, such as the McLean County Health Department, BroMenn Healthcare, OSF Promptcare, Healthpoint, Sports Enhancement and various specialists in the Bloomington-Normal area.

As good as the program was and still is, it is acknowledged that as one cycle of leadership draws to an end, opportunity beckons to begin a new era of leadership for the future as changes continue to take place in the dynamic dual environments of higher education and healthcare. In this context, the findings that follow may seem insignificant to some but to others they are meaningful and worth considering to advance the program.

FINDINGS

1. Meeting the needs of those eligible for services.
 - a. SHS is not currently offering comprehensive care as “advertised”. Mental health care services are in a separate administrative unit although partially funded through SHS with a portion of the mandatory health fee each semester. And, no rehabilitation services are offered, despite the notion that the program is a comprehensive care facility.
 - b. The episodic care needs of students are well-attended but there appears to be no overall plan for chronic disease management.
 - c. As part of a health service on an academic campus, there are opportunities for research and publication, yet none were reported.
2. Program elements that need additional resources.
 - a. Professional development. Despite attempts by the SHS Executive Committee and Advisory Council members to foster opportunities for staff development activities on campus, the staff feels there is a disconnect between administration’s good intentions and what staff experience. Also, too little funds are reported to be available to support staff interests in attending national or regional college health meetings to keep better informed about college health issues.
 - b. Leadership development.
 - c. Pharmacy. Space is inadequate to meet the storage, counseling privacy and dispensing demands of pharmaceuticals and to enable students to have direct access to over-the-counter drugs.

3. Communicating the availability of services.
 - a. Students expressed confusion about what is covered by the health fee and what is covered by the Health Insurance Plan premium. More attention could be devoted to communicating with students, parents or the university community about the SHS program.
 - b. On May 16, 2005 marketing professors Jeri Mullins Beggs, PhD and Brent A. Beggs, PhD presented the results of the campus-wide survey they administered, analyzed and interpreted. The high quality survey conducted during the fall 2005 semester was designed (1) to determine why the number of visits was declining, (2) confirm hypothesized reasons for the decline, (3) assess respondents (both users and non-users) attitudes about SHS and (4) explore possible changes. Based on the survey findings, plans are underway to develop a marketing campaign to be implemented during the fall 2006 semester.
 - c. It was reported in the Self-Study CPR that the SHS Web Oversight Team (including professional staff from the Office of Institutional Web Support) created a new SHS website that went live October 2006. The site is updated periodically and is designed to address communication issues such as noted above.
 - d. The perception is the SHS program is too isolated and not well connected with the academic community where planning also takes place vis-à-vis five-year reviews.
4. Health Promotion.
 - a. Health Promotion's "G Spot" traveling gazebo and its Toilet Talk postings in restrooms are viewed as learning opportunities and are well received by students.
 - b. Health Promotion staff collaborate with academic departments to provide practicum and internship experiences for students and staff serve on several campus committees.
5. Administrative separation of the Student Counseling Services (SCS) program from the SHS program.
 - a. The administrative separation of the two programs is transparent to students who are of the understanding that SCS is part of the overall SHS program.
 - b. The structural independence of the two programs does not promote an atmosphere of collegial collaboration among health promotion staff, health care providers and counseling staff to the extent possible by complementing the skills of the respective staff in students' best interests. This situation exists in spite of the respective director's cordial relationship and attempts to bring staff in both programs closer together.
 - c. ** Study the need for additional behavioral health services in consultation with the Student Counseling Service and Student Affairs Administration. It is essential to reconcile the differences between the student health program data and the increases reported by the Student Counseling Service and shown by national data.*

RECOMMENDATIONS

1. Reconsider the value of strengthening the partnership between the SHS and the Athletic Department to provide Rehabilitation / Physical Therapy services as delivered by certified Athletic Trainers (ATCs). The pilot project in place about a year ago was discontinued following lack of interest and support by the campus President. SHS staff considers the decision unfortunate given the demonstrated positive outcomes during the trial period.
Sports medicine: Both injury prevention and rehabilitation for bones, joints and associated soft-tissue injuries have a role in helping students maintain or restore themselves to a high-level wellness in order to help them be successful in their academic pursuits. Health services for scholar athletes get a lot of attention for obvious reasons. Per capita, student athletes are well attended and have access to resources for injury prevention (athletic trainers) and rehabilitation (orthopedic surgeons and physical therapists) far more readily than students not engaged in intercollegiate athletic activities. And yet, many students not involved in intercollegiate sports are actively engaged in intramural activity and self-directed wellness activity with similar risks to musculo-skeletal injuries as the scholar athletes. Yes, they are injury prone and do get hurt in the middle of their wellness activity, be it racketball, pick-up basketball, volleyball or soccer. The difference lies in non-athletes lack of access to injury prevention and rehab. An excellent segue to gaining “access for all” is by obtaining the confidence of Athletic Department officials and coaches to partner with the SHS to provide primary care services for athletes, arrange for some athletic training services to be provided at the SHS and hire a provider with special training and interest in Sports Medicine to coordinate a program of services to which all students would eventually have access. As a result, all students would likely minimize delays in receiving care and the Athletic Department could reduce its costs (and liability) associated by not having to transport as many athletes off-campus for clinical services.
2. Given the amount of professional contact that the Office of Disability Concerns staff needs to have with both SHS and SCS staff in order to effectively carry out its mission, consider including Disability Concerns in the administrative framework of the SHS.
3. As a complement to patient satisfaction surveys conducted each fall and spring, bi-annually administer a web-based stratified random sample survey to 10% of all students to assess their knowledge of, satisfaction with and utilization of the SHS program. For example, it is important to learn why students are by-passing the SHS if they need health care. It is also important to learn of students’ perception of the program, even if they are not users.
4. As ISU continues to enhance its health promotion program, the focus should be sharpened to emphasize evidence-based, theory-driven, documented prevention initiatives with an ecological approach that enhances student learning and is distinctive from marketing, advertising, or public relations.

5. Continue administering the ACHA-NCHA and the CORE Alcohol and Drug surveys. Use the data to describe the collective health status of the student population and assist with defining an overall strategic plan and scope of services for health promotion. The ecological approach promoted by National Association of Student Personnel Administrators' (NASPA) "Leadership for a Healthy Campus" and the ACHA tools should guide program enhancement.
6. Use the following findings of the Beggs survey conducted Fall 2005 to develop a marketing campaign to better inform ISU students about the wide array of health services available to them and help them be good consumers of such services now and in the future.
 - a. There is a lack of awareness concerning the array of services available, costs and eligibility issues.
 - b. There is a preference for continuity of care (same provider for repeat visits).
 - c. Students proximity to home affects their usage of SHS.
 - d. The majority of females are establishing a relationship for women's health before arriving on campus.
 - e. Respondent prefer e-mail for communication.
 - f. Non-users
 - Many ISU students have not sought health care since attending ISU.
 - Students are likely to have another health care plan.
 - They are more likely to be male than female.
 - They are not using the so-called "doc in a box" locations.
7. Contract with a "nurse advice" service to take calls from students when SHS is closed.
8. Develop procedures for managing increasing numbers of students who present with chronic illnesses to assure continuity of care.
9. Seek ways to collaborate with academic departments for research opportunities as an effective means of strengthening the campus and SHS connection. * *Facilitate clinical research with Mennonite College of Nursing at ISU, Department of Health Sciences, Athletics Department, Department of Kinesiology and Recreation.* (CPR, p. 50)
10. Promote the availability of allergy maintenance/desensitization services to faculty and staff. Doing so reduces loss of work time and a nominal charge for such service can be used to underwrite costs of providing the service. * *Notify ISU employees of services available at the SHS, i.e., allergy shots, on-the-job injury care.* (CPR, p. 51)
11. Address the concerns (1) that 'structural and cultural' problems exist between SHS and SCS staff, (2) Health Promotion and SCS programs overlap, and (3) the perception by SCS staff that victims of sexual assault seen by SHS staff are not being referred early enough to SCS staff.
Comment: Item three (3) above needs attention to minimize any discord between the Sexual Assault program staff and SCS staff. The respective parties must come to agreement on their respective roles. For starters, it is recommended that the Fall 2005 AAAHC consultation statement be used to

begin the dialogue. Specifically, “The Sexual Assault Coordinator is responsible for assault survivor support, initial needs analysis, and then advocates for the survivor through the maze of the Criminal Justice System and University Judicial System. During the past six years, 96% of survivors have been retained at the University. Privacy, anonymity if requested, unlimited support visits, and advocacy have been the main concerns and motivations in contrast to a counseling therapy program. The individual performing this service provides high professional services campus-wide. The exceptional results speak for themselves.”

** Review the relationship and interdependence between the SHS and SCS, e.g. shared funding, psychiatric services, credentialing and peer review of psychiatrist and psychiatric nurse. (CPR, p. 50)*

12. Coordinate health-related resources from the SHS program, the SCS program and academic programs with health interests to create a wellness culture across campus, with SHS staff assuming a proactive leadership role for the campus community.
13. Add ‘Fitness and Nutrition’ to the areas of emphasis for Health Promotion staff.
14. **Allow students to obtain specific information about their care (i.e. lab test results) without face-to-face contact, e.g. i-campus, e-mail, automated phone system. * (CPR, p. 41)*
15. **Revise and simplify the appointment making process (review instructions given to patients, standardize appointment lengths and types, etc.). * CPR, p. 41)*
16. **Improve customer service by implementing a check-out station, e.g. assess fees, provide bills, evaluate patient satisfaction. (CPR, p. 41)*
17. **Improve the provision of observation and monitoring services (including extended-care services such as IV re-hydration, observation for possible appendicitis, injectable analgesics). (CPR, p. 41)*
18. **Determine how observation care can continue to be provided safely through the identification and reallocation of existing resources. * (CPR, p. 42)*
19. **Articulate the health needs of students to the university community to assure decisions, directions, institutional policies, and resources are based on accurate information. * (CPR, p. 46)*
20. **Improve communication with central administration and academic administrators regarding the purpose and function of a student health program in a university community. (CPR, p. 51)*
21. **Re-establish an active SHAB (Student Health Advisory Board) that will advocate for health services on behalf of all students. (CPR, p. 48)*
22. **Maintain accreditation with a nationally recognized accreditation organization and CLIA. (CPR, p. 55)*

B. Staffing

Consultative comments: Decisions about staffing are driven by historical data, current experience, and by future projections of consumer demand and health behaviors. It is also helpful to participate in benchmarking initiatives to gauge how various program elements compare with health service programs on other campuses. Other factors to consider include: ease of access, patient flow, continuity of care, and relationships with the greater ISU health care community.

Commendation

1. Credentialing and privileging of providers is a high priority in validating credentials which are essential to maintaining quality standards of professional conduct. The credentialing process has been outsourced to the University of Iowa Clinical Staff Office, an accredited Credentials Verification Organization.
2. Time is allotted during staff work schedules to enable them to participate in a variety of staff development/training activities. Depending on work demands and funding, release time is authorized for staff to participate in off-campus professional meetings or conferences.
3. Several staff members assume leadership roles in local, state and national organizations germane to campus health service activities.
4. Diversity and cultural competence is a priority for the program's leadership as evidenced by the two-year agreement with the Mennonite College of Nursing faculty to conduct training sessions intended to enhance cultural sensitivity and awareness in the workplace and to better serve an increasingly diverse student population.
5. Staff quality is perceived to be quite high and the staff is valued by other members of the university community.

Findings

1. Discussions about expanding hours to better serve students were met with resistance by staff who seemed reluctant to consider a flex scheduling arrangement involving Saturday or evening hours.
2. The configuration of clinic space makes it difficult for staff to more efficiently manage fluctuating patient care demands and to collaborate with each other in terms of sharing the workload or consulting with each other.
3. There is an inordinate amount of processing of patient-related paper given the technology today to use more cost effective methods for computerizing forms and records.
4. Best practices protocols have not been adopted by clinic providers who tend to practice in their chosen way, independent of the practice patterns/behaviors of other providers. A patient's follow-up care with a different provider may adversely affect the quality of care.

5. Given the nature of the population to be served, there appears to be an imbalance in staffing with too many physicians and too few advanced nurse practitioners.
6. Staff members want to be valued, trusted and recognized for positive performance by others in supervisory or leadership positions. And, they want to be better connected with the mainstream issues of the university to better understand university politics.
7. Communication among staff was characterized more as “top-down” than “bottom-up”.
8. Morale is an issue for nurses who feel they are not treated as professionals. One factor is their civil service classification.
9. Supervisors span of control is unevenly balanced. For example, the Assistant Director of Nursing oversees nearly one-third the SHS staff.

Recommendations:

1. Revise the organization chart to more closely align supervisory staff according to skill sets and inter-related duties and responsibilities. For example, RNs, LVNs and non-licensed personnel could be supervised by an RN. Consider the most functional supervisory relationship for APNs. The current Assistant Director of Nursing position could be re-classified as Assistant Director for Health Services and work collaboratively with the Medical Director.
Comment: If the structure of the SHS program changes by adding the SCS and Disability Concerns, the organization chart will take on a whole new look. Options include expanding the Director title to either Executive Director or Assistant Vice President for Campus Health Services, with the Medical Director and SHS Administration Director, SCS Director, Disability Concerns Director and Health Promotions Director on a direct line report.
2. In the event of provider staff vacancies, consider hiring males to achieve a better gender balance.
3. Re-evaluate staffing for the SHS to assure that adequate numbers of clinical, clinical support, and administrative staff are available (academic year and summer) and that their skills are appropriately aligned to meet patient demands. In the process, consider demand management strategies (virtual health library, after-hours nurse advice line, computer kiosks with direct links to credible on-line health information, etc.) as an effective means of arriving at a staffing level that is complemented by non-traditional (but effective) ways of meeting students’ many low acuity, self-limiting, and self-manageable medical concerns.
4. Re-evaluate the mix of RNs and other clinic support staff. Decisions about the staffing mix stem from the agreed upon goals of the organization. If providing care is the main driver, a mix of hiring Medical Office Assistants or Nursing Assistants would be more practical than using more highly trained RNs. On the other hand RNs provide valuable service if their skills are appropriately applied, either as a complement to providers or independently

with approved protocols for various clinical tasks such as immunizations, allergy injections, wound care, etc. * *As services evolve and change, define and plan for the most appropriate clinic staffing mix, and study the functional roles of the different nursing classifications.* (CPR, p. 40)

5. The Lab staff is highly trained and consideration should be given to partnering with the Lab Tech academic program so SHS Lab Tech can serve as preceptors for students by using the lab as a “laboratory for learning” while providing direct service.
6. Cross train someone from the lab to substitute in radiology when necessary to assure the service is available during all clinic hours. Note: Training will require licensure to function as a radiology technologist. Training will require time away (perhaps during summer months) and costs.
7. Further develop in house “experts” in areas like dermatology and orthopedics.
8. Integrate Medical/Counseling/Health Promotion services to maximize continuity and coordination and hire a staff psychiatrist to help coordinate care (from prevention initiatives to hospitalization for mental disorders) for the increasing numbers of students attending higher education with more pathology than in prior years.
9. RN staff positions with RNs functioning at levels below their training should either be eliminated or their work duties should be redefined to enable them to function at a level commensurate with their training.
10. Establish “care teams” to enable physicians and advanced nurse practitioners to be “teamed” with support staff (RN, LPN, MOA) to promote continuity and consistency in patient care according to best practice standards. Include the provision of being flexible to enable staff to achieve more evenly distributed sweat equity with work demands as patient demand fluctuates from one part of the over-all clinic to another.
11. Standardize care for common problems among all providers, include phone protocols. This should include not only infectious diseases, but chronic illness- asthma, diabetes, etc. Develop templates (scenarios) that can be part of future EMR applications.
12. Relations between appointment schedulers and health care providers and between RNs and health care providers could be improved by additional training of schedulers to help them better understand what is expected of them.
13. Hire someone with formal training and experience in medical coding to facilitate electronic claims filing to insurance companies.
14. Help staff stay current on trends in college health by arranging for teleconferencing or participation in state, regional or national meetings.
15. Provide release time for staff with special skills and interests to participate in guest lecturing and collaborating with faculty involved in health-related research activity.
16. Arrange for staff to attend staff enrichment programs on customer service and monitor student/patient feedback with periodic customer satisfaction surveys.

17. Consider more formal development of strategic partners to routinely “outsource” problems like colorectal problems, allergy, orthopedic and gyn pathology issues that are beyond the expertise of SHS providers.
18. Weigh the variety of MAKE or BUY decisions in service delivery to meet the clinical care, health education and mental health needs of ISU students in the most cost-effective way. One example is lab testing, deciding what tests to do on site (if any) and what to refer out to a reference lab. Costs/benefits must be weighed, including concerns about quality of care and convenience to students. Another is phone triage, whether to hire and train staff to do it in house or to contract with an outside resource.
19. Hire a primary care physician with special interest in office orthopedics or sports medicine training to better serve the primary care needs of student athletes and non-athletes with similar needs, to manage the referrals for students specialty care needs and to provide medical over-site for the cadre of athletic trainers.
20. Administrators and supervisors are advised to make a conscious effort to find staff “doing something right” as an effective means of praising staff and engendering feelings of value, trust and appreciation.
21. Make decisions about staffing after the program scope of services is defined and a financing scheme is agreed upon.
22. Increase the visibility, contact by administrative staff in clinic areas so staff has opportunities to ask questions, seek clarification of issues and express concerns as an effective way of breaking down the perception “the program is ‘top heavy’ with administrators and we don’t understand what they do.”
23. **As the triage process evolves, consider the possibility of utilizing nursing staff to perform triage and to make appointments. (CPR, p. 41)*
24. **Obtain greater diversity among the staff and assist staff in fully appreciating the need for diversity training and the advantages it can bring in providing services. (CPR, p. 54)*
25. **Restructure the management of the organization using Systemic Leadership principles (e.g., number of committees, types of meetings, membership on various administrative groups). (CPR, p. 55)*
26. **Define the need for psychiatric services and respond to the expectation that staff provide additional mental health services. (CPR, p. 40)*

C. Financing and Insurance

A dedicated student health fee, an allocation of institutional funds (tax dollars and tuition), student insurance and group health program reimbursement, charges for services...or, any combination thereof...currently represent the varying means of funding the college health service program. There are pros and cons of the different financing schemes. And, each year many student health care administrators face the challenge of financing their programs with enough money to, at the least, maintain essential services. Relying on only the health fee or only on the allocation of institutional funds or only on charges for services to

underwrite program costs is not very realistic in today's competition for financial resources. The health fee has its limits and it competes with a myriad of other fees students are assessed. States that are in dire financial straits because of too few tax dollars available for higher education are gradually eliminating an allocation of such funds to finance their campus health program. And, reliance on charges for services at community rates neutralizes any competitive advantage of on-campus health care services.

Fees for services model. Escalating financial pressures are forcing colleges and universities to move to a fees-for-services model to underwrite the operating costs of the campus health services program.

While historical data related to students' demand for chargeable services and good data on the services actually provided in the previous year are a relative gauge of potential patient revenue, there is no guarantee from one year to the next that patient demand will remain stable. As the environment changes and the cohort of eligible, potential patients/customers changes, a decrease in demand could have a dramatic and adverse impact on the financial viability of the program. Similarly, an increase in demand could overwhelm existing resources, leading to long waiting times, briefer visits, and highly stressed staff. Another downside is the financial barrier to access (visit charge comparable to community rates) for some students, especially for those who are uninsured or underinsured and have little or no means of reimbursement for out-of-pocket medical care costs.

To be successful, the fee-for-service model is dependent on a combination of the number of students who walk through the door and the chargeable (and collectable) services they receive. Also, the services provided under this model tend to be limited to those that generate revenue...mostly clinical in nature, to the exclusion of primary prevention (health promotion and disease prevention) that generate little, if any, revenue. Other variables include students' personal finances, perception of the quality of the program, and the type of insurance coverage (if any). If "the pain in the wallet exceeds the pain in the belly", they will bypass the program and either ignore the problem, resort to self-remedy or wait until they go home to see their family doctor. If they belong to an HMO and are "out-of-network" and are "functionally uninsured" when on campus, they are also more likely to bypass the campus health service program.ⁱ

Caveat. The prospect for success using the fee-for-service only model (no allocation, no health fee), as well as for the "Gold Standard" model discussed below, can be enhanced with a mandatory with right-of-waiver (hard waiver) health insurance policy. Students' who are required to purchase the campus-endorsed medical insurance plan because they either do not participate in another plan or their plan does not meet established minimum coverage benefit thresholds are helping assure financial stability of the student health program if the plan provides hassle-free reimbursement for chargeable (insurance reimbursable)

services. Furthermore, if the health service is able to assist students with filing claims and accepts assignment of claims, the health service and students alike are the beneficiaries. That is, the health service captures the revenue and the student's out-of-pocket costs are either eliminated or reduced and the financial barrier to access of campus-based health services is eliminated or lowered as well.

College health is at the nexus of two worlds, both of which are feeling great financial pressure...higher education and the greater healthcare community. When juxtaposed with "real world healthcare" on the one hand, and with the academy on the other, college health workers are sometimes made to feel like the Rodney Dangerfields of each world...we get no respect.

The Gold Standard is the student health service that functions as an auxiliary operation of the university, is financed by a combination of an adequate and clearly identified health fee and charges fees for selected services that are competitive with the local market. Auxiliary programs in universities are designed to pay their own way. They function as a business and survive on a delicate formula that ensures that revenue will exceed expenditures. They employ staff sufficient to meet consumers' demands, have well-defined policies and procedures that govern daily actions, adhere to rigorous standards and best practices, and adapt to the fluctuating demands and sensitivities of students wants and needs.

The Gold Standard model insulates, but does not isolate the student health service program from other parts of the academy that may find itself under inordinate financial pressure caused by decreasing tax dollar support; projects independence and self-determination; promotes accountability; is more proactive than reactive; preserves the college health model; and, applies sound business principles.

Migrating to the gold standard for those not already there (such as the ISU SHS) does not have to be an onerous undertaking. It will, however, require a shift in the institution's philosophy and resistance can be anticipated. The timing, however, could not be better given the trend in recent years because of shrinking state support of higher education in Illinois, limits on increasing fees and changes in healthcare reimbursement.

Value of the health fee. The health fee is of real value and includes entitlements. The fee makes it possible to dedicate resources (personnel, materials) to campus-wide, primary-prevention initiatives, including promotion of healthy behaviors. Since these invaluable services do not generate fee-for-service revenue, the use of a portion of the health fee as a principal funding source is justifiable. Even for that student who does not have a need for clinical care, the health promotion and disease prevention programs and services are available and have been demonstrated to reach most students at some time during their academic career. The health fee is akin to the premium paid for a basic insurance policy that provides certain benefits. By spreading the risk over the entire student

population, the health fee may obviate, or at least reduce, the need to institute a visit charge to help cover the program's expenses...a cogent argument over the previously discussed fee-for-service model, which tends to "financially penalize the user for getting sick or for seeking care" because of the access fee (visit charge) and for various charges for services at usual and customary rates.

Setting the health fee. The fee is a form of capitation that each student is required to pay to underwrite the costs of providing an array of health services. Setting the health fee is no small challenge. If one subscribes to the concept of "budget to the plan", the first task is to clarify the student health service's plan to ensure the program is the driving force in determining what the health fee should be. The challenge is greater than the financing by allocation method (which forces one to "plan to the budget", limiting the scope of services to the funds available), but the outcome is more rewarding and meaningful. Many factors come into play. What does the historical experience regarding patient demand suggest? Are there unmet primary prevention and clinical needs identified from survey research? What is the extent of other health-related resources on and off campus? What is the age, gender, nationality of the population to be served? What is the residential/commuter mix? What are the options regarding staffing ratios, the number and type of staff necessary to provide the required scope of services (include or exclude counseling/mental health and health education services?) What are the operating costs (historical and projected)? What is the appropriate funding for depreciation of the physical plant and equipment and/or funding of capital project reserves?

Regarding this last question of funding capital projects, do not underestimate the value of the facility where health services are provided. What does it look/feel like (welcoming, aesthetic)...configured to promote confidentiality/privacy, patient flow re. intake and egress? Since students (like most health care consumers) make decisions about quality of care with their eyes, if the facility doesn't "look" like it provides quality care, opinions are quickly formed and these initial impressions are hard to reverse...even if all other "invisible" measures of quality are considered (accredited, staff credentials, latest technology, etc.).

One approach to setting the semester health fee is to determine the funds that will be required to cover all or most of the fixed costs of the program, namely salaries, fringe benefits, liability insurance and institutional overhead charges (if any). The balance of the budget – operating costs – can be made up by charges for services paid for by cash or through health insurance reimbursement. To simplify, take the total annual fixed costs (using historical budget data plus any substantive reductions or enhancements to the scope of services) and divide it by the projected annual student enrollment to determine the student health fee per year. Divide that number by two to arrive at the semester health fee. (Some campuses weight the semesters differently, and most have a separate fee for the summer session.) The clearly identifiable health fee "spreads the risk" among all students and is set at a level which provides assurance that specified services will be

available when needed and that any associated charges will be kept to a minimum compared to prevailing rates in the local community – a real competitive advantage for any college health service program.

Setting charges for services. Times, they are a-changing. The practice of “give away medicine” is history for many, if not most, college health service programs today. Medical economics are not what they used to be. The realization that underwriting the escalating costs of providing medical care services for students is diverting precious, dwindling funds necessary to support academic needs have pushed many campuses to reduce or eliminate university (or state) funds associated with financing campus health service programs. If the decision is made to assess fees for those services/procedures typically reimbursed by health insurance plans, setting charges for those services can be difficult. Most universities want to price their services close to, but below, the prevailing rates in the surrounding community. Trying to gain access to “charge masters” from area clinics and hospitals, however, can be a frustrating experience. Another option is available from the Healthcare Financial Management Association, which publishes a Customized Fee Analyzer called “MEDICODE,” which enables an organization to compare its fees against national benchmarks. (The address is Ingenix, Inc., 2525 Lake Park Blvd., Salt Lake City, Utah 84120.) Perhaps finding the median charge for various services (50% charge more, 50% charge less) in your area will serve as a gauge to set your own charges. You may find it advisable to set the fees at or below the median charge as an additional benefit of paying the health fee...having access to services at charges lower than prevailing rates in the surrounding community.

Sowing the seeds for success. It’s all about leadership. It’s about knowing what to do and how to do it. A well-crafted student medical insurance plan that reimburses the student health program for chargeable services makes a significant contribution to the financial health of the program and provides a return on the premium students pay as an investment students’ make to lower the costs of the medical services they need. In summary, the Gold Standard of financing:

- Provides dependable revenue from the health fee;
- Includes direct reimbursement to the student health service program from the institution-sponsored medical insurance plan for chargeable services covered by the plan;
- Promotes the college health model: health promotion, disease prevention, clinical services (and, counseling and psychological services under a campus health services umbrella);
- Makes a statement of value...spreads the risk...helps the institution protect its investment in its students by promoting retention;
- Provides entitlements...facilitates access and sets charges for services below community rates;
- Reduces costs associated with the higher education experience; and,
- Makes “budget to the plan” more viable.

The Gold Standard method of financing sees its finest hour in times of economic distress. It helps insulate the campus health service from the financial stressors of state- and tuition-supported administrative units. This is most evident in those states where severe budget cuts in higher education are crippling growth and stability of programs throughout the campus community. And yet, health service programs independent of tax dollars and functioning as a self-supporting, auxiliary operation are being spared if the following conditions are met: the program is well managed; is fiscally sound; is meeting the needs of those served; receives high marks for customer satisfaction; has the confidence of constituent groups, especially those who manage the annual fee-review process; and has the endorsement of any faculty member, administrator or staff member who would say “If I was sick or hurt and needed medical attention, I would use the student health service for my primary care needs...as my first choice, if I were eligible to do so.” Now, that’s a “Gold Standard” outcome!

Commendation

- 1. The ISU health fee.** The health fee recognizes the distinctiveness of the college health services program and places a clear and visible premium on health services provided. The separate, identifiable health fee makes a statement...that the health service program is a value-added resource to the academic community, accessible to all students for the express purpose of helping them maintain a level of wellness and functioning to achieve academic success. It is separate from all other tuition-related benefits of the institution and recognized as such. And, the health fee is a relatively easy sell, especially to parents who know how expensive health care is, or can be, if minor problems are exacerbated by delays in receiving care. Having ready access right on campus is also an easy to understand asset.
- 2. Mandatory health insurance.** It is a credit to ISU officials who have instituted a mandatory hard waiver health insurance plan for ISU students. Not only have ISU officials taken great pride in recent years in noting that about 90 percent of their students are enrolled in their Health Insurance Plan, but the peace of mind in knowing that financial help is available to help pay medical bills and thereby lower the risk of interrupting students’ academic progress provides great comfort to campus officials, students and parents alike.

Findings

1. The projected flat-line in student enrollment at ISU provides no increase in revenue generated by the health fee for the foreseeable future.
2. There has been a gradual erosion of the fund balance each of the past three years due to a number of factors, including: an increase in the fringe benefits

costs, professional liability premium increases, maintenance cost increases, increasing costs of pharmaceuticals, technology upgrade costs, capital equipment (Lab); and a transfer of funds to help financially support the Counseling Center and the Disability Concerns programs. Many of these costs are unique to the SHS program, requiring sound business practices and fiscal planning to remain solvent.

3. The Health Insurance Plan and its interaction with the SHS are confusing. Many SHS staff members do not have a good handle on how the insurance plan works or what benefits either the health fee or the insurance plan provides. One can infer, therefore, that neither many students nor their parents know the various features of the plan.
4. The Health Insurance Plan design has exceeded its period of functional practicality in terms of its contribution (or lack thereof) to the financial health of the SHS program and is in need of a substantial re-design to provide a win-win-win structure for the principals, namely: subscribers (adequate benefits at lowest possible premium), the SHS program (reimbursement for services), the insurance carrier/broker (reasonable fees to cover retention costs and make a profit), ISU (student retention, lower financial risk and minimum complaints), and parents (satisfied the plan is meeting the needs of their students in helping reduce out-of-pocket health care costs).
5. Present circumstances raise serious concerns about the financial health and survivability of the SHS program unless new revenue streams are identified.
6. Students are confused as to why they are not billed for services. They say it is cumbersome to go get a bill statement from the insurance office to submit an outside claim.
7. **Limited resources are available to address health/educational needs identified by the CORE Drug and Alcohol and National Collegiate Health Assessment (NCHA) surveys which include cold/flu incidence, stress, nutrition, sleep deprivation, and smoking. (CPR, p. 45)*

Recommendations

1. Use recent surveys/needs assessments to determine whether or not a change in the scope of services is advisable. Determine the most desirable model: adopt a more comprehensive campus health services program with counseling and psychological services, clinical services, health promotion and possibly Disability Services under one administrative umbrella.
2. Depending on the model, determine fixed costs (personnel, fringe benefits, etc.) to make adjustments in the health fee. Use historical information to determine operations costs given cost of living and medical inflation index projections for the next 1-3-year time periods.
3. Institute charges for services to cover operations costs (30% or more of the total budget). Charges should be set below community rates as a benefit of paying the health fee and the charges should be limited to those that are typically reimbursable by health insurance plans.

4. **Obtain the actual cost of all SHS in-house lab tests and the cost of sending those tests, for which a same-day result is not required. Determine the impact, cost-benefit, and savings to students and the SHS if referring selected tests (GC, Chlamydia, Group A strep, and urine culture) to reference lab or directly billing students for these procedures. (CPR, p. 43)*
5. Eliminate the Front Door fee to take away the financial barrier to access. At the present \$5, it is more of a nuisance fee that requires almost as much in staff time as it does to charge the fee. Unlimited visits at no charge represent an entitlement of students' paying the health fee. This encourages early intervention, diagnosis and treatment (if necessary) and helps reassure the "worried well" without incurring additional expense. "Swapping" the Front Door Fee with various charges for services will not only take away the financial barrier to access, the money lost from eliminating the Front Door Fee will be offset by higher revenue from those charges for services that are reimbursable by health insurance plans.
6. Re-design the Health Insurance Plan to pay most, if not all, of the charges for services incurred at the SHS for those students who participate in the ISU Health Insurance Plan who do not have other insurance. For students who participate in the ISU plan but who have a primary payer plan through their parents employer, provide an exit statement suitable for them to file with their parents insurance plan. Depending on the benefits paid according to their parents plan, any co-pays or deductibles would be eligible for reimbursement by the Student Health Plan upon verification with payment statements provided by the student. Doing so encourages students to use the campus health service and the program derives the benefit of the revenue from diagnostic tests (lab, x-ray) and various medical procedures, thereby helping assure sufficient revenue is available to support the SHS budget.
7. Develop a marketing plan to clearly articulate the benefits provided by the health fee and the Health Insurance Plan.
8. Automate the claims process and provide students with an exit statement suitable for filing with private insurance plans. Electronic courtesy filing, without accepting assignment, should be considered in the future.
9. Plan to accept payment for services by credit card, check, cash, or the campus card. Or, arrange to bill the student's account and require payment before registering for the next term.
10. Merge the business affairs of the program with the insurance office to streamline the operation by automating as much of the work as possible. Use the billing features of the PyraMED practice management system and interface with other parts of the clinic to capture billable charges (i.e. lab, pharmacy).
11. Dedicate time to finding public/private companies and governmental departments, along with ISU alumni association, to obtain grant monies to help defray costs associated with various program initiatives, i.e. tobacco companies to provide sponsorship for non-smoking programs, alcohol companies to provide sponsorship for responsible drinking programs, health vending machines more liberally placed on campus, Employee Assistance

- Program to assist in joint student-employee program for specific on/off-campus issues...to identify a few.
12. Facilitate access to OTC products by redesigning pharmacy space to include a separate area for OTCs. ** By July 1, 2007, prepare a business plan to determine the feasibility of a full-service retail pharmacy including: expected revenue, cost, space and staffing.* (C:PR, p. 42)
 13. If space can be identified, add eye care services (optometry and eye glasses) by outsourcing to an optometrist to lease the space through an arrangement that derives financial benefit to SHS (through the lease and, perhaps, a percentage of visit charges and sales of eye glasses or contacts.
 14. **Eliminate patient confusion regarding differences between purchasing health services and/or student insurance.* (CPR, p. 47)
 15. **Identify the pros and cons of sharing resources between SCS and SHS such as: common appointment staff, telephone triage, support staff such as medical records and reception, clinical management information system, administrative staff, shared fiscal oversight, and psychiatric services.* (CPR, p. 51)
 16. **Continue to ensure that financial resources are available to recruit and retain staff by offering competitive salaries.* (CPR, p. 54)
 17. **Identify ways to reduce costs, e.g., more cross training of staff, eliminate infrequently utilized services that have high costs, determine appropriate staffing mix.* (CPR, p. 56)

D. Facility and Technology

Commendation

1. The Student Services building housing the SCH, the SHS program and other student services is prominently placed, easily accessible with parking, well maintained, handicapped accessible and its aesthetic, professional appearance is welcoming.
2. Investment in the computerized practice management system, PyraMED, positively positions the SHS program for future technology changes affecting the healthcare industry, including the practice of medicine and business procedures necessary to thrive in a highly competitive environment. PyraMED will enable staff to automate their billing services, analyze data related to patient care services, gradually transition into a paperless system toward an electronic health record and interface with a Laboratory Information System to facilitate ordering and receipt of lab test results. Longer term, providers will be able to access patient records electronically both internally and externally with community clinics and hospitals.

Findings

1. A Clinical Applications Team (CAT) was created to develop and implement a plan to phase-in an Electronic Health Record (EHR).
2. Health Stop has a prime location and is well organized but seems to be underutilized.
3. Clinical providers are resistant to using technology to facilitate patient care record keeping.
4. The Pharmacy space is inadequate to accommodate the demand. There is no privacy for counseling students about their drugs. OTCs are not easily accessible.
5. The waiting area in Clinic 2 is premium space that is seldom used.
6. **As a “distributed support” unit at ISU, SHSIS reports directly to and is accountable to the SHS and the Student Insurance departments. This arrangement provides better response times, satisfactory outcomes, and more detailed/custom support than a vendor or central support unit can provide. (CPR, p. 60)*

Recommendations

1. Facilitate learning by installing computer stations in the patient waiting areas to enable students to gain access to health information ranging from frequently asked questions about SHS to the myriad of health topics of interest to students. Consider developing a virtual health library website with hyperlinks to other sites with credible health information (pre-screened according to criteria established by SHS staff). A financial benefit of having access electronically is a reduction in printing costs for the many pamphlets currently available to students. Pamphlets become dated and additional costs are incurred in revising them. ** Expand patient education material availability on-line from SHS website. (CPR, p. 62)*
2. Appoint an applications specialist to train providers and others about PyraMED features related to patient care, business practices and data reports. Comment: Physicians and advanced nurse practitioners should be the drivers of the migration from paper records to the EHR. Once the benefits are clearly understood and the skills are refined, use of the present technology applications greatly enhance the overall program by facilitating access to protected health information, decreasing errors, increasing the quality of care and decreasing liability. If the SHS providers were practicing in another clinic setting, more likely than not they would not have a choice in using the technology or not. It's simply a practice requirement.
3. Install computer kiosks, strategically placed in clinic waiting areas for students to use as an effective means of accessing credible health information prior to or following an appointment.
4. Create a web-enabled health history form to obtain essential information from students as a pre-matriculation requirement and map the data to PyraMED for ready access to providers during clinical visits.

Comment: Collecting such information electronically makes it possible to aggregate data and get a profile of students health status each semester. This information provides real value to more directly target health promotion programs and identifies students with chronic conditions that need on-going maintenance care.

5. Expand the pharmacy to meet the increasing demand for prescription drugs; include private space for counseling about drugs dispensed; and configure an adjacent area where students can self-select OTC products competitively priced. * *Meet the demand caused by increased prescriptions from outside providers, third party insurance, and transfers.* (CPR, p. 41)
6. Reconfigure Clinic 2 to use the waiting area for clinical care services. Two or three exam rooms may be added to more efficiently accommodate patients during times of high demand.
7. Migrate from plain film to digital radiography to stay abreast with the changing technology for medical imaging and to facilitate the electronic transfer of images for radiologists to read and more quickly return interpretations to ordering providers. * *Determine gains (efficiency, productivity and information sharing) by implementing a Picture Archiving and Communication System (PACS), and Digital Radiography.* (CPR, p. 42)
8. Install a computerized Laboratory Information System that interfaces with PyraMED and Quest (reference lab) to facilitate ordering, test results and billing.
9. Dedicate blocks of time in each providers schedule to enable students to make their own appointments with their provider of choice for continuity of care or to maintain a relationship with a provider previously seen.
10. Maintain the SHS intranet with essential, up-to-date program-related materials, including clinic protocols for various staff, policies and procedures, minutes of committee meetings, itemized charges for services, etc.
11. Housekeeping services staff should be under the supervision and training of the SHS to assure Environment of Care standards for accreditation are maintained. The facility should be well maintained with a professional appearance and regular maintenance should be scheduled to minimize any disruption in services.
12. After defining the program's scope of services and staffing requirements, obtain the services of a facilities planning and design expert in clinic services to study the current facility and recommend a configuration of structure and functional changes that will more efficiently "package" the services.
13. **As needed, reallocate/renovate space to follow changes in service delivery, e.g., combining Business Office and Insurance Office, self check-in stations, dermatology, orthopedics, athletic trainers.* (CPR, p. 58)
14. **In conjunction with Student Affairs, develop a long range plan to maintain and fund infrastructure repairs in the Student Services Building, e.g. roof repair, water heaters.* (CPR, p. 58)
15. **Implement electronic pharmaceutical ordering and prescribing (e-prescribing) that is compatible with the developing national Health Information Infrastructure, the Health Insurance Portability and*

Accountability Act, Consolidated Health Informatics Initiative and consistent with National Council for Prescription Drug Programs script standard for transmitting prescriptions electronically. (CPR, p. 60)

16. **By November 2, 2006, contract with Media Highway to review clinic operations and recommend ways to increase clinic efficiency through greater use of PyraMED software (clinic management information system and additional staffing. (CPR, p. 60)*
17. **Install an automated telephone voice response system which allows patients to request Rx refills. (CPR, p. 61)*
18. **Allocate resources from the SHS budget to meet growing technological needs. (CPR, p. 62)*
19. **Implement secure electronic communication methods with patients. (CPR, p. 62)*

III. Summary

Take the best of what you have and make it better.

Where to from here? The future rests with the philosophy espoused by higher administration officials. What role and value do student health services play in students' academic success? What is the optimum structure and function of the program to assure the health needs of ISU students are being met?

How these probing questions will be answered depends on the resources made available, the priorities that are agreed upon and the leadership in place to effect the changes that address the changing dynamics within the co-existing worlds of higher education and healthcare.

Because of its pervasive influence on the program's financial health of the future, the immediate challenge is the need to restructure the health insurance program. The current plan has served its time. The scope of benefits, the relative bargain price of the premium, use of the Premium Stabilization Reserve, overall management of the plan by ISU SHS staff has been commendable when compared to many student health insurance plans across the country. While it is impressive that nearly 90% of ISU students participate in the mandatory plan, the plan needs careful scrutiny. In its present form, the benefits encourage enrollees to seek their care elsewhere... a clear threat to the financial viability of the SHS program's future. A sea-change in operations that involves instituting charges for services (those that are typically reimbursable by insurance companies and are priced at lower than community rates) and redesigning the health insurance plan to pay the SHS for those same services the plan is currently paying outside providers will help alleviate

much of the financial stress the program is certain to face in the future. (See discussion beginning on page 27.)

The CPR is the starting point. The process of strategic planning for the program's future will follow. The outcome of this effort will provide the roadmap for the program's future. The priorities for that future include: program leadership, services that meet students needs, a financing scheme (including a student health insurance plan that reimburses the SHS program for services it provides) that assures fiscal viability and accountability, a pattern of staffing that provides complimentary skills and competencies and a facility that "measures up" to environment of care standards and is functionally supportive of cost-effective and efficient services. The foundation is strong. Building on that strength in the most constructive ways is tomorrow's challenge. Best wishes...from the SRT members.