Student Health Center Annual Report for the Fiscal Year 2021 2022

Primary Purpose

The Mission, Vision, and Values of the Student Heath Center are as follows:

MISSION:

We support student well-being and success by providing quality evidence-based healthcare and wellness services, advocating for students and empowering them in their healthcare decisions, and being an integral part of the larger University of Utah community

VISION

The Student Health Center is committed to developing and improving lifelong health and wellness skills for all University of Utah students.

VALUES

Quality

Advocacy

Empowerment

Community

Departmental Outcomes

Our main departmental outcomes are measured thru continued AAAHC Accreditation, Patient Satisfaction surveys, and our Quality Improvement Program.

Accreditation:

The Student Health Center is accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) and remains the ONLY accredited student health center in the State of Utah[1]. We were accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) after our initial onsite survey in April 2013. Prior to that time the SHC was accredited by the Joint Commission. The AAAHC accredits all the other school health centers in the PAC-12 and is a much better fit with college health, having additional standards encompassing health promotion and travel medicine in addition to the traditional areas. The organization is more collaborative and consultative than the Joint Commission and places a larger emphasis on quality improvement.

The AAAHC was established in 1979 to advance and promote patient safety, quality of care, and measurement of performance. The American College Health Association was a charter member of the organization. AAAHC accreditation demonstrates a clinic's commitment to safe, high quality services to patients and promotes a culture of continuous improvement.

[1] http://www.acha.org/ACHA/Resources/Topics/accredited_schools.aspx

Initial accreditation involves a 2 day on site visit by a surveyor who examines all policies, procedures, and care provided by a clinic to make sure it meets all of their standards in areas such as governance, administration, rights of patients, quality of care, clinical records, infection control and safety, and facilities and environment. After initial accreditation, the organization is subject to a site visit approximately every 3 years to demonstrate continued compliance with the organization's standards.

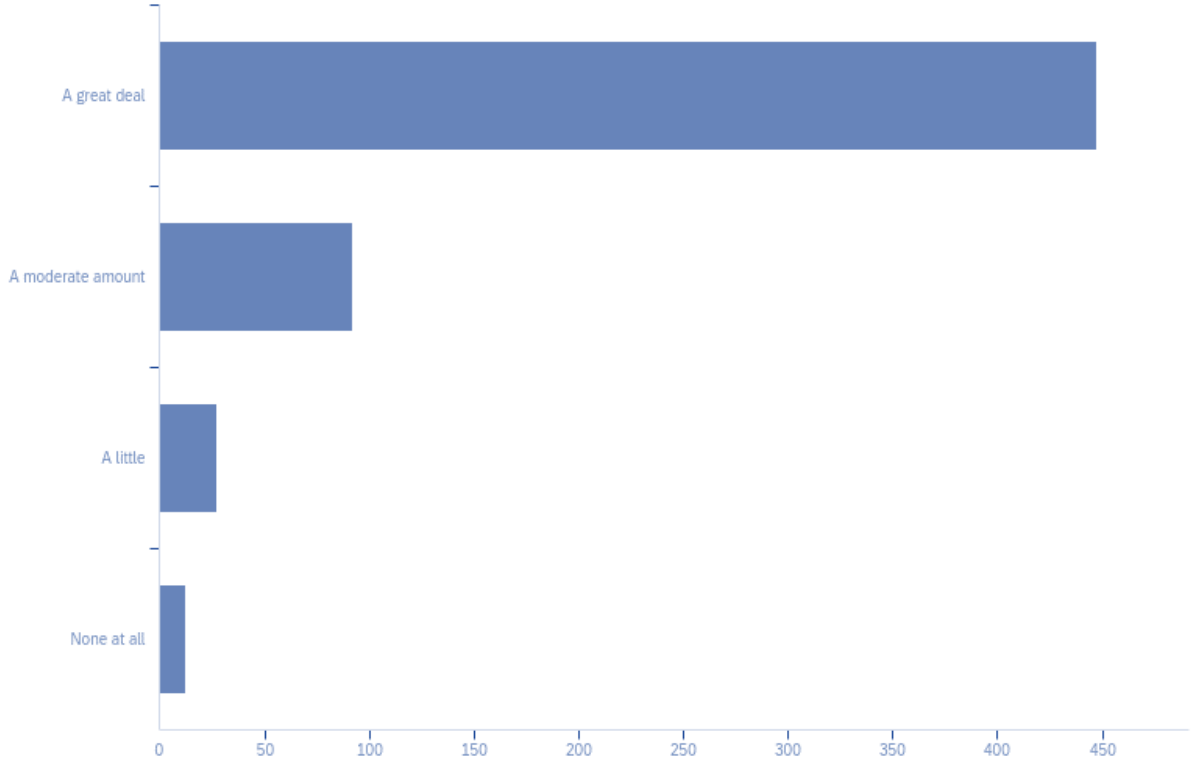
After initial AAAHC accreditation a reaccreditation site visits occurs every 3 years. The center had a successful reaccreditation visit in March 2022 with no deficiencies noted.

Patient Satisfaction & Quality Improvement

The SHC Quality Management Program is ongoing, data-driven, and integrates professional peer review and risk management in an organized, systematic way. Two formal quality improvement (QI) projects were completed in 2021-2022. The first project stemmed from updated clinical guidelines on asthma evaluation and management that were published in 2021. Primary care providers (PCPs) at the University of Utah Student Health Center (SHC) suspected they were not fully adhering to these guidelines when seeing students for asthma. Through provider education and adoption of an EMR tool provider adherence rate to these clinical guidelines increased from 46% to 73%. The second project was facilitated by professional peer review that revealed a lack of adherence to the CDC's Guide to Taking a Sexual History. Through provider performance feedback and adoption of an EMR template provider adherence rate to the guide increased from 43% to 82%.

The SHC has collected patient satisfaction data using a rolling online survey since 2014 to ensure that we meet student expectations of care and support their return to normal activities following illness or injury. Patients receive these surveys 48 hours after a visit, both nurse only and provider visits. These results are summarized and shared with staff at the end of each semester at scheduled QI staff meetings. With the onset of the pandemic and the change to telehealth, telehealth specific satisfaction survey questions were added. In 2021-2022 survey response rate averaged 14%. An average of 97% of respondents agreed or strongly agreed on survey questions relating to staff communication, clinic efficiency, adherence to careful handwashing practices, overall satisfaction, ability to return to normal activities as a result of their visit to the SHC, and their desire to recommend the SHC to family and friends. There was no difference between in person and telehealth visits in terms of patient satisfaction. Below is an example of one of the survey's questions:

To what extent did this visit support your ability to return to your daily activities (e.g., attending class, completing assignments, going to work, playing sport, parenting a child)?:



Programs, Services, and Resources with Impact Data

Healthcare provision to students, spouses, and dependents

The SHC provides both acute and preventative care to students, their spouses, and children both in person and via telehealth. Services include those typical of a large general care practice combined with some specialty services:

- Adult and child well care
- Acute care visits for illness
- Women's health visits
- Contraceptive care
- Sexually transmitted infection diagnosis, treatment, education, and prevention
- Sports medicine
- Travel medicine
- Psychiatric consultation

All of these services are complemented by laboratory, radiology, and pharmacy services through U Health and ARUP Laboratories.

The COVID-19 pandemic continued to play a huge role in our center. The University, transitioned back to in-person classes in Fall 2021 from all online instruction the prior year per legislative decree. We were also not allowed to require masks on campus. However, masking was still allowed in healthcare facilities which our office continues to do. We saw a large drop off in provider appointments from the beginning of the pandemic in March 2020, which remained diminished while classes were all online. This past year, we returned to more normal numbers once the school year began as shown in this chart representing provider appointments (nursing visits excluded).

	Appointment Date												
	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
FY 2016	433	466	602	626	527	458	559	620	634	615	517	459	6,516
FY 2017	387	519	623	574	579	458	603	555	615	573	490	499	6,475
FY 2018	435	525	542	618	565	389	611	578	655	607	582	347	6,454
FY 2019	366	521	485	650	612	440	632	598	620	723	570	466	6,683
FY 2020	498	548	666	679	562	501	659	566	370	194	283	318	5,844
FY 2021	319	345	451	483	380	295	423	367	492	415	369	405	4,744
FY 2022	350	459	531	532	580	437	530	513	698	599	481	505	6,215
Grand Total	2,788	3,383	3,900	4,162	3,805	2,978	4,017	3,797	4,084	3,726	3,292	2,999	42,931

Obviously with the return to school and no masking requirement, illness related visits increased. As we had done in the prior year, we continued to vigorously screen patients for COVID19 symptoms and allowed those without symptoms to be seen in clinic, and scheduling those with upper respiratory symptoms to a telehealth visit with the option to be seen in person at a provider's discretion. We encouraged those who were scheduling to utilize the campus test resources if not previously screened for COVID19. We also provided students information on various virtual visits available via U Health, Intermountain, or as part of the student health insurance plan on our website. Due to the need for social distancing in our small clinical space, we continued to not allow walk-ins for immunizations, TB testing and laboratory testing; these were scheduled by appointment. To make things easier for the student, we began offering online appointments via our patient portal for prior walk-in visits (given the large amount of information that needed to be conveyed regarding an in-person provider appointment we held off on opening up all appointments for online scheduling). The walk-in volume previously handled on a very busy day is now seen over 3-4 days. Anecdotally, many students told us they preferred having scheduled nursing visits rather than the ability to walk in as service was quicker. Given the continued high transmission and recurring waves (now experiencing BA.5 wave), we plan to continue scheduled nursing visits indefinitely.

Like many other facilities, we did not do COVID19 testing in our clinic but referred students to our campus testing resources that were developed over the course of prior year. The campus's coronavirus website provides information on testing resources. The University offers both asymptomatic and symptomatic PCR COVID19 testing. Vending machine options for asymptomatic testing was added midyear with results back within 24 hours.

The majority of the visits were students, with 7% of the visits being spouses or dependents. Of those total encounters, the majority were for illness related concerns (92%) with the remainder of the visits being well care. The majority of all visits were with students who had their charges billed to some type of health care insurance. Only 9% who presented for a visit had no insurance provider listed. Of those with insurance, 87% had the student health insurance plan. These numbers may be misrepresentative of the entire University population. Many students with private insurance, will be covered better elsewhere (SHC is only in network with the student health insurance plan), and are directed to other

University clinics in our building or another provider (e.g., if they have SelectHealth, Intermountain is there preferred provider). We do bill other insurances as an out of network provider. Additionally, those who only need an immunization will have those covered 100% at an in-network provider as mandated by the Affordable Care Act. Thus, we will direct those students to local clinics and or pharmacies to receive those vaccinations.

Of all patients seen by a provider, 30% were new patients to our practice. Beginning in 2010, we began tracking encounters with both international students and U.S. Veterans. We saw 1722 international students and 56 veterans for the 2021-2022 period for provider visits (nursing visits for immunizations only are not included in this total). International student encounters increased 36% over the prior year as international students were again able to attend classes in person after a year of travel restrictions.

In addition to provider visits, students also interact with our nursing staff as they work to meet the Proof of Immunity Requirement (see Immunization Requirement section below) through immunizations and antibody titers as well as the tuberculosis screening requirement for new international students. Nursing staff also play a role in triaging of ill students both in person and via the phone as well as drawing routine labs students need either by their student health provider or by a subspecialist they see elsewhere.

Our nursing staff continues to have incredibly busy years. As mentioned above, nursing visits which where typically not by appointment (walk-in) became scheduled to allow adequate social distancing. The chart below shows nursing visits (immunizations, TB tests, lab draws) by fiscal year with a similar drop-off as provider appointments but now has returned to more normal levels despite the change from walk-in to by appointment:

	Appointment Date												
	July	August	September	October	November	December	January	February	March	April	May	June	Grand Total
FY 2016	175	884	650	500	633	345	345	278	291	361	344	353	5,159
FY 2017	282	977	715	490	448	267	382	258	350	371	294	262	5,096
FY 2018	245	766	505	574	446	229	535	265	316	336	307	194	4,718
FY 2019	262	876	597	596	423	256	451	320	265	298	327	269	4,940
FY 2020	349	823	1,030	729	446	337	489	296	181	68	114	130	4,992
FY 2021	173	300	370	443	330	173	156	156	185	168	150	160	2,764
FY 2022	232	426	680	453	384	327	338	311	392	307	237	238	4,325
Grand Total	1,718	5,052	4,547	3,785	3,110	1,934	2,696	1,884	1,980	1,909	1,773	1,606	31,994

Due to COVID, we largely discontinued PPD's for tuberculosis screening and transitioned to the IGRA blood test for screening, as the latter only requires 1 patient visit versus the two for PPD's to be read (IGRA testing does not require the student to come back to have the test read, but is more expensive). 169 PPD's (29% increase) and 1793 IGRA (58% increase) were done – an expected increase as international students returned to campus (in the prior fiscal year our domestic students made up the majority of those tested). We had previously piloted IGRA testing for international students as an option, but had increased rates of syncope after blood draws, probably owing to a number of factors: summer heat, elevation change, and jet lag for the new students, and thus elected to predominately use the PPD and reserving the IGRA testing for specific circumstances. Anecdotally, we did not experience similar syncope episodes this past year as we fully switched over to IGRA. We allow our international students to have their IGRA testing done in their home country since this is a standardized test. We never accepted PPD's done in home countries due to a high level of variability in results. Only international students from certain countries with high incidence of tuberculosis are required to be

screened. For the past 6 years, we allowed students to do their TB risk questionnaire online through our patient portal rather than coming into our office to complete the paperwork. If it is positive, they are instructed to come in for testing.

An additional 562 MMR's (measles, mumps, and rubella vaccine) were given to those students who lacked immunity, a 127% increase – owing to students returning to campus and not having them done elsewhere as they did when classes were online. Titers done also increased to 167 (titers were performed for the diseases that make up the MMR which is an alternative route to MMR compliance) a nearly 200% increase, again owing to return to on campus classes.

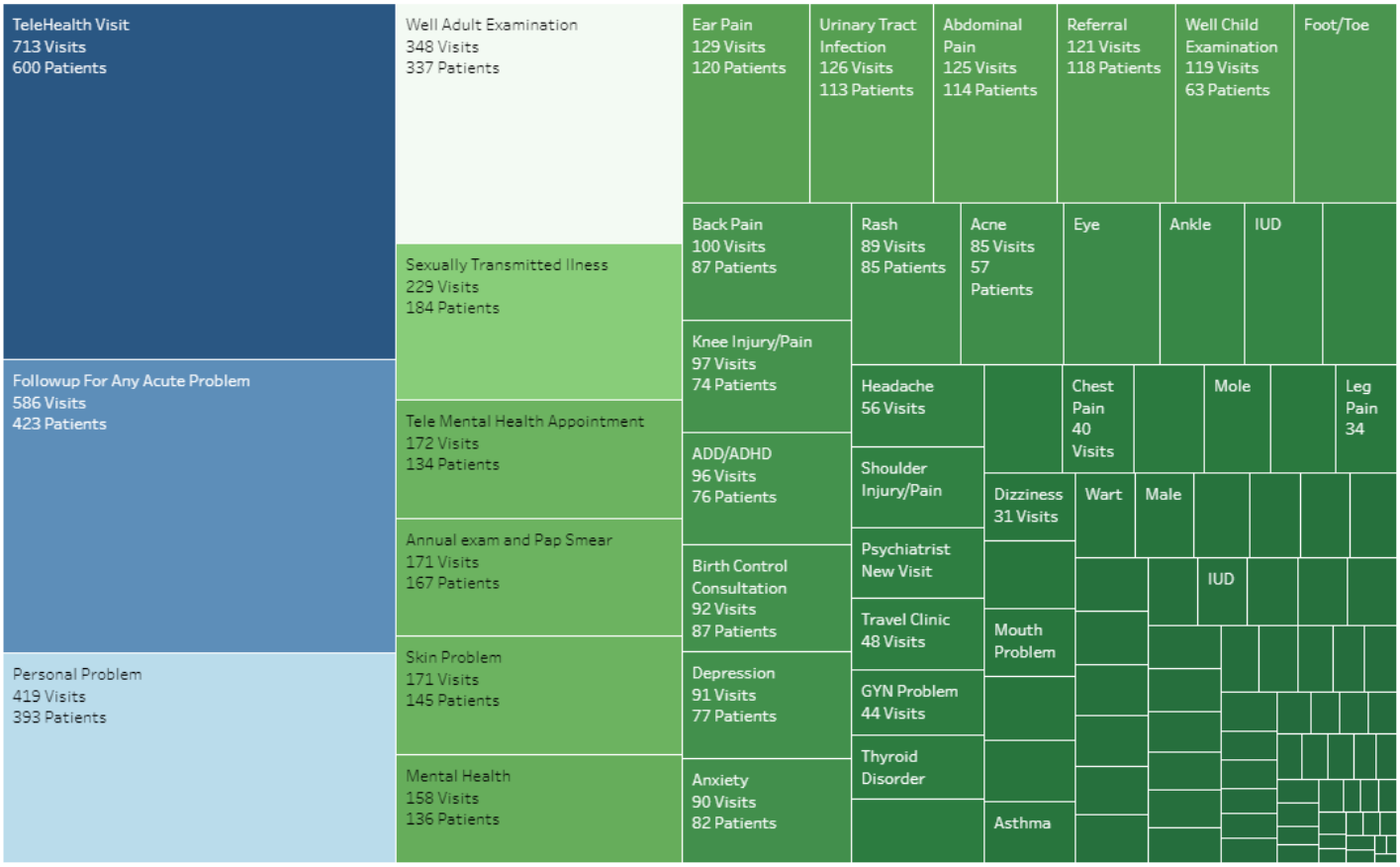
Finally, we gave 1022 flu vaccines versus only 245 the prior year as students were back on campus. In years past our number was closer to 1800 as ASUU will fund flu shots and work with the Center for Student Wellness for up to 3 student flu shot clinics throughout the fall semester. Prior to the pandemic ASUU wished to get away from funding these clinics. Our office had discussions with CNS (Community Nursing Services) about providing some campus clinics; CNS can bill most all insurances for the vaccine and has funding for those without an ability to pay. CNS did some limited flu shot clinics (drive through) in the fall after the pandemic began. CNS then transitioned to assist with large scale COVID vaccine clinics on campus once vaccine became available for the college age group in May 2021. During these COVID vaccine opportunities in the subsequent fall, flu vaccine was also made available.

The clinic started receiving the COVID19 from the state at the end of April 2021. We chose the Moderna product as it was able to be used with our existing vaccine freezer. Since then we have given 1191 doses of the vaccine in our office (dose 1: 518, dose 2: 244, booster: 409). Unfortunately, given this vaccine comes in a multidose vial (10 doses) that must be used within 12 hours of initial puncture, 1331 doses were wasted. We initially attempted to schedule vaccine doses on only one day to decrease waste, but as the vaccine became more available we began to give whenever possible.

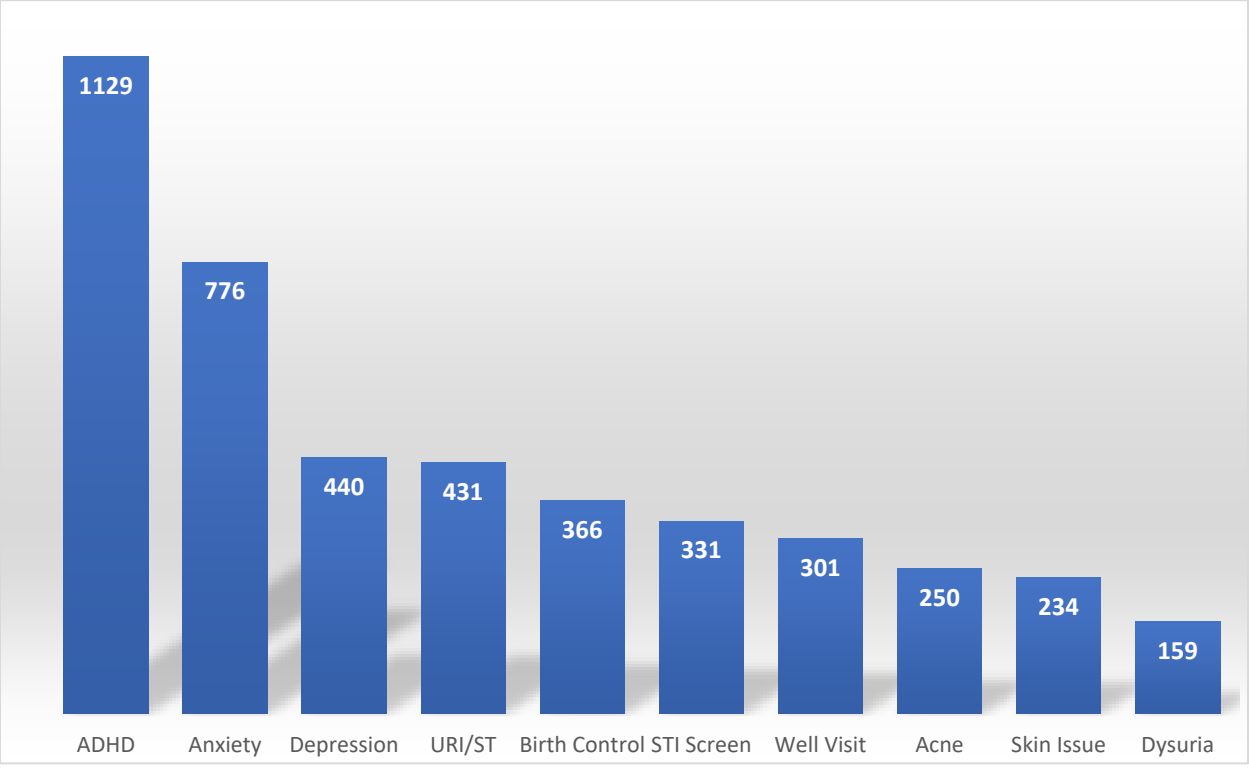
The clinic also offers a prescription assistance program for those who cannot afford the cost of medications utilizing existing programs within the pharmaceutical industry. The number of students utilizing this service has decreased to almost zero due to the Affordable Care Act as many no longer qualify as they have insurance with a prescription benefit or the pharmaceutical company has discontinued the program.

The Travel Clinic provides pre-travel consultation for students, staff, and the community on a fee-for-service basis. The clinic is staffed by two nurse practitioners, 1 of whom hold specialty certification from the International Society of Travel Medicine. The latter practitioner retired during the fiscal year and assisted the other provider with training and how to seek certification. The clinic specializes in the provision of comprehensive destination-specific risk assessment, education in the risk and risk reduction for international travelers, and provides appropriate evidence-based medication prescriptions and immunizations for prevention and treatment of problems encountered abroad. Due to COVID19, our travel clinic appointments were severely impacted (During a normal year, we do between 130-150 of those visits), but steadily improved. While doing only 2 visits during the first have of the fiscal year, 45 visits were done in the latter half as travel returned.

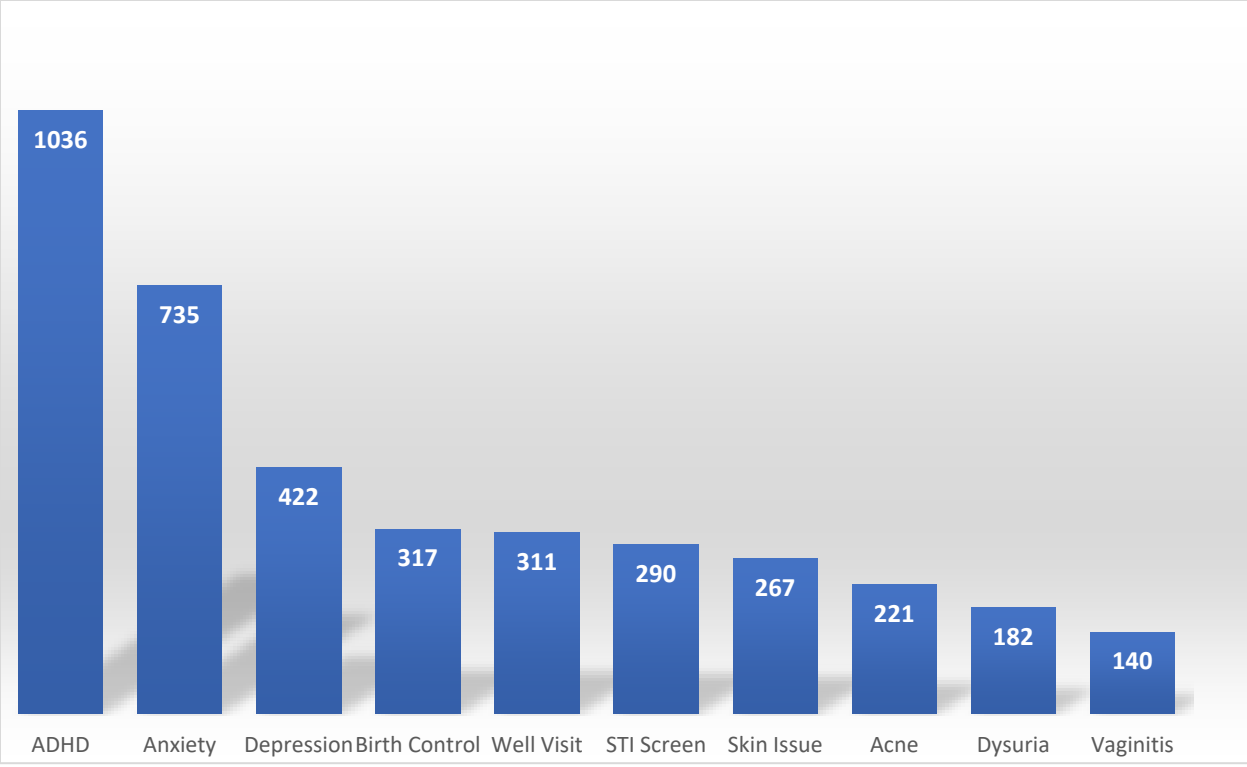
Below is a graphical representation of Appointment Reason for the 2019-20 fiscal year (nursing visits not included), followed by the Top 10 Diagnostic Codes used (ICD10). The majority of telehealth visits were for those with upper respiratory symptoms who hadn't yet tested for COVID19.


TeleHealth Visit
713 Visits
600 Patients
Followup For Any Acute Problem
586 Visits
423 Patients
Personal Problem
419 Visits
393 Patients
Well Adult Examination
348 Visits
337 Patients
Sexually Transmitted Illness
229 Visits
184 Patients
Tele Mental Health Appointment
172 Visits
134 Patients
Annual exam and Pap Smear
171 Visits
167 Patients
Skin Problem
171 Visits
145 Patients
Mental Health
158 Visits
136 Patients
Ear Pain
129 Visits
120 Patients
Urinary Tract Infection
126 Visits
113 Patients
Abdominal Pain
125 Visits
114 Patients
Referral
121 Visits
118 Patients
Well Child Examination
119 Visits
63 Patients
Foot/Toe
Back Pain
100 Visits
87 Patients
Rash
89 Visits
85 Patients
Acne
85 Visits
57 Patients
Eye
Ankle
IUD
Knee Injury/Pain
97 Visits
74 Patients
Headache
56 Visits
Chest Pain
40 Visits
Mole
Leg Pain
34
ADD/ADHD
96 Visits
76 Patients
Shoulder Injury/Pain
Dizziness
31 Visits
Wart
Male
Birth Control Consultation
92 Visits
87 Patients
Psychiatrist New Visit
IUD
Travel Clinic
48 Visits
Mouth Problem
Depression
91 Visits
77 Patients
GYN Problem
44 Visits
Thyroid Disorder
Anxiety
90 Visits
82 Patients
Asthma

Top 10 Diagnostic Codes Used



For comparison, the following is the prior fiscal year's (2020-2021) Top 10 diagnostic codes used:



As can be seen, following national trends, we are seeing more mental health related concerns our center which has only been exacerbated by COVID19. Illness visits vary by year, normally driven by how severe the influenza season is. This past year was odd in that we still rarely saw flu, but other illnesses occurred outside of their typical season.

Diagnostic coding uses ICD10 which has nearly 70,000 distinct codes. Thus, providers may code similar illnesses differently. The above represents a consolidation of some codes; however, it may be underrepresenting certain conditions and/or visit reasons. Numbers represent use both for patient visits and/or medication refills which may elevate some diagnoses due to prescribing requirements (e.g. ADHD).

Immunization requirement(s) for University students

MMR Requirement

The University of Utah requires all new, transfer and readmitted students born after 1956, who do not have medical or religious contradictions for MMR vaccine, to show proof of immunity to the diseases of Measles, mumps and rubella. This requirement began in 1993. The Utah State Legislature passed a law in the Spring of 2021 requiring higher education to now also accept personal exemptions. The law took effect in May 2021 and we have not seen a noticeable increase in MMR exemptions overall. Anecdotally, most students who had a personal exemption reason in the past would convert it to a religious one such that we may not see marked difference with this change.

Students can meet this requirement by providing documented vaccines for two doses measles vaccine, two doses of mumps vaccine, and one dose of rubella vaccine, or two MMR vaccines after they were one year of age. They may also meet the requirement by providing documented blood test (titer) to show immunity to measles, mumps and rubella. An exemption from the requirement may be given for medical, religious, or personal reasons. (See the "Healthcare provision . . . " section for numbers of tests/immunizations performed). By the end of the semester, MMR compliance is typically 98-99%.

COVID19 Requirement

The Utah State Legislature also passed another law in Spring 2021 preventing any state entity from requiring the COVID19 vaccination while the vaccine is under Emergency Use Authorization (EUA). The Pfizer COVID19 vaccine was FDA approved on August 23, 2021 – the first day of Fall semester classes. A COVID19 vaccine requirement was then announced to students on August 31, 2021 which consisted at that time of a primary series of the Pfizer vaccine (2 doses); any other vaccination under EUA (Moderna/Johnson & Johnson) or WHO approved vaccine obtained internationally was also accepted. Given the late announcement into the semester, students were given until the end of October to provide their COVID vaccine dates and records, or apply for an exemption. This was a huge undertaking for our office. Typically, we are doing compliance for ~5000 new students during a typical fall semester. Suddenly we needed to comply ~33,000 students within 2 months with this new requirement. Luckily, we had invested some years ago in an interface between our electronic medical record (EMR) and the State of Utah vaccine registry, USIIS, which automatically queried students as they came into our system and then again monthly for any new vaccines. We knew from preliminary data in the Summer of 2021 that approximately 68% were already compliant with the new requirement. However, that still left a sizeable number of student records to review. Our EMR vendor also provided compliance services and we quickly enlisted them as an adjunct to our very small staff. Given the hiring environment and time to train individuals, using this service allowed us to hit the ground running. By the end of October, 87% of students had complied, with 6% of that number representing exemptions. Approximately 6000 registration holds were then placed upon the remaining students.

Four days prior to the start of the Spring semester, with the Omicron variant causing massive increases in cases and hospitalizations, senior administration decided to require a COVID19 booster. This information was quickly relayed to students. We again called upon our EMR vendor to assist with compliance. This was a much more difficult process to manage given that there were approved intervals between primary and booster doses depending on the vaccine originally given (which also changed during the course of this requirement). As many only had gotten their primary series completed in September/October, they weren't actually due for a booster until March/April. Thus, students were gradually becoming booster noncompliant and then needed messaging to remind them that they were now due for the booster. In addition, we typically warn students of registration holds in early February and then place holds toward the end of February which would then prevent registration for their next semester (Summer or Fall). As registration opens in late March/April, students would be becoming noncompliant as they were registering for classes and thus the registration hold was less effective. By March 1, approximately 9000 students were noncompliant with the booster requirement. Given the declining Omicron surge by that time and the number of potential holds, senior administration instructed our office to not enforce the booster requirement and instead strongly encourage boosters. By the end of the semester, 63% of students were boosted, with 28% booster. Exemption percentages remained stable throughout with around 6% claiming an exemption. The remaining students had some combination of exemptions plus some doses or hadn't yet submitted data to our office. Over compliance with the 2-dose primary series was thus 91%. For summer semester at the time of this report, overall booster compliance has gradually increased to 67% and compliance for the primary series

was at 93%. Our booster vaccination rate is much higher than the community rate, with between 32-40% of college age individuals being boosted.

Medical/Dental Student Requirements

Beginning fall 2012, the Student Health Center began assessing immunization compliance for the School of Medicine (SOM) students. The School of Medicine students are required, upon admission, to show proof of immunity to/and or be vaccinated for: measles, mumps and rubella (MMR); tetanus, diphtheria, and pertussis (TDap); varicella; and Hepatitis B - along with an annual TB screening and influenza vaccine. Medical students who fail to comply with this requirement have a registration hold placed on their enrollment until the requirements are met. For continuing students, they are unable to proceed with clinical rotations until compliant. COVID19 vaccine was added in Fall 2021 (see above discussion). The only variance from other students is that personal exemptions are not allowed (state law excluded personal exemptions for students in the health professions). They also required additional documentation for medical and religious exemptions.

These students have 100% compliance with their requirement. With the COVID requirement, we had only 9 exemptions. One medical and the remaining religious, mainly among the dental students. We began assessing compliance for the Dental School fall 2015 with the same requirements as the School of Medicine. Other health professions students have their immunizations tracked by their home department, but many come to our office to meet their requirements through immunization and/or titer. This past year our office worked with the AVP For Health Science Education who was responsible for both medical/dental and other health science student's compliance with this new COVID19 requirement. We worked with the Assessment Office to provider our vaccine data to them who then was able to create a dashboard for the AVP office to use to monitor compliance and exemptions.

International Student Tuberculosis Screening Requirement

Although not an immunization per se, we also assess compliance with tuberculosis (TB) screening for our international student population. All international students from countries with a high prevalence of tuberculosis as determined by the World Health Organization are required to undergo screening for tuberculosis. Those who screen positive but are found to have latent tuberculosis are offered treatment through the Salt Lake Valley Health Department to prevent going on to active tuberculosis. Failure to be screened also results in a registration hold (see the Health Services area above for numbers of tests performed). For Fall 2016 we began using an online tuberculosis screening questionnaire on our student portal. It links to ICM for our international students. Those with negative responses are automatically compliant. Those with a positive questionnaire received instructions to come to the SHC for additional testing. This greatly reduced the need for international students to physically appear in our office to comply with this and the immunization policy.

Compliance with Requirement

The Immunization Compliance Module (ICM) of Medicat allows us to totally manage all compliance. Subsets of students can easily be emailed within the system regarding their status. All vaccines/TB testing that occurs in our office automatically link to the ICM. This allows them to become compliant automatically and their holds removed electronically twice daily thru a system interface, facilitating prompt removal of holds. This has been a vast improvement over our prior paper method.

The Medicat system has a patient portal which interacts with the ICM. Students can go online, login to our system, provide dates of immunization, and scan their existing records into our system. Our compliance officer verifies their vaccinations and the software marks them as compliant. We phased out

the prior paper immunization compliance cards in May 2016. Previously we had no storage for vaccine records when student submitted their dates. The ICM allows online storage. Thus, our providers can readily access the records and the students can log in to the portal and print a copy if needed. As of August 2016, we require records from all students. To aid ease of student use with the portal we changed the login procedure to use the student's university ID and password in late summer 2021.

For new students a welcome letter is emailed via our ICM once the student has paid their enrollment deposit explaining the immunization requirement with steps explaining how to submit their immunization records via an online student portal. Students receive frequent updates of their status after submission until compliant. Four weeks after the beginning of each semester, those students who are not compliant with the immunization requirement are sent an email that notifies them a hold will be placed on future registration (e.g., a registration hold) until they have complied with both dates and provided records of their vaccines for verification. The new COVID19 requirement is now a part of this process.

Thus, noncompliant students are unable to register for classes the following semester without complying. Our current system allows us to monitor compliance daily and in real time. Prior to the COVID19 vaccine requirement, 700 – 5000 holds are placed per semester, with the majority in Fall semester and less in Spring and Summer semesters (see COVID19 specific hold numbers in the discussion above). In November 2018, the Utah State vaccine database, USIIS, began interfacing with our Medicat system. Any student with records in the database had their immunization records automatically imported in to our system and were immediately complied if they had the required immunizations. The number of registration holds for noncompliance placed in the first semester after its implementation were down by 2/3 of the normal (~1500 holds down to ~500). MMR vaccination rates >90-95% are typically needed for herd immunity to measles to prevent its spread. At then end of Spring semester 2022, for ALL requirements (MMR, COVID19, TB), compliance was 98.6%.

Student Health Insurance Plan (SHIP)

Narrative/Utilization Data:

The contracted insurer for the University of Utah Student Insurance plan during this fiscal year is United Healthcare Student Resources (UHCSR); United has been the insurer since 2013. The plan consists of a subsidized graduate student plan for teaching assistants and research assistants, a mandatory plan for international students and a voluntary student plan for all others. As the plan is voluntary, other students either utilize their parents plan, choose their own or an employer plan, or are uninsured. Eligible students can also enroll a spouse and/or dependent(s) on the plan; some graduate departments subsidize this cost as well. Those students who graduate and had been previously on SHIP can elect to pay for a continuation plan for up to 6 months as a bridge until they start a new plan. The 2021-2022 plan also included a Special COVID19 enrollment for those students who were unable to enroll for fall semester.

The SHIP provider is determined by a competitive bidding process every 5 years; plan design and rate changes are discussed yearly by our staff, the graduate school dean and benefits coordinator, and our insurance broker. Meetings are also held with constituent committees (see below). Plan benefits are largely determined by what the graduate school can afford to pay for the policy given they subsidize the

cost for their students between 80-100%. Monies for this subsidization come from grants and state appropriated funds. Thus, any changes/improvements to the policy can cause premium increases which may be unaffordable to the graduate school and even more unaffordable to those students who purchase without subsidization.

This past year, we had a Student Insurance Advisory Committee meant to be comprised of ASUU representatives as well as an undergraduate, graduate, and international student representative. Given COVID and travel issues we were unable to have any international student members. Students provide feedback regarding the plan, discuss plan changes with the renewal and associated costs for any additional services students might wish the plan contain. During the fall semester, concerned graduate students submitted a petition asking for changes to the Dean of the Graduate School. We had the insurance advisory committee included in the several meetings that were held, explaining the insurance process, pricing, reasons for certain limitations with some requested changes being made. We did agree to some changes; most notably an increase in the prescription drug benefit to 90% reimbursement from 50% (per ACA, some medications are reimbursed at 100%).

A very small student fee subsidizes clinic operations allowing professional fees to be 40-60% less than typical charges for similar services in the community as well as near cost charges for immunizations, laboratory, and radiology which represent a sizeable savings to those that are uninsured or lack a local network provide. Coverage for transgender care/sexual reassignment surgery was added to the 2016-2017 policy. For the plan year (2021-2022) the cost was $2269. Due to a higher than normal loss ratio (mainly among spouses and dependents), as well as improving some aspects of the plan, the yearly insurance premium will increase by approximately 9.5% This is an increase of $217 per student, per school year resulting in an annual cost of $2486 for the 2022-2023 plan year. The increase will also apply to each additional insured in each household.

We reviewed possible enhancements to the current prescription coverage (e.g. a more traditional prescription benefit card rather than a 50% reimbursement method). Those changes would add an additional $250-$360/year to the plan premium. In response to student input, we were able to secure an increase in the prescription reimbursement from 50% to 90% for the 2022-2023 school year.

Our current contract allows yearly renegotiation and allowances for plan changes. We added a Tele-Doc function to the policy 6 years ago which allows insured to call for medical advice after hours. Four years ago, we added a virtual counseling component, allowing students to receive counseling via text, chat, or phone. Both of these services are available at no charge for those on the insurance. Students have viewed these options favorably. Students without the student insurance plan can access these services for a minimal fee (e.g., $45 for Tele-Doc).

Due the timing of this report (current plan year ends August 15, 2022), we do not have current policy year end data for loss ratio. However, for the last full plan year that we have data (2020-2021 plan year), the student loss ratio was 80.67% while the spouse/dependent loss ratio was 131.92%. Insurers prefer a loss ratio of 80% or less.

<u>Subsidized Graduate Student Health Insurance</u>

The Graduate School provides an 80% subsidy for full-time Teaching and Research Assistants (some departments provide a 100% subsidy). The subsidized graduate plan is combined with the University-sponsored student insurance plan. Both plans cost the same and provide the same benefits. They also provide a separate vision/dental plan.

Voluntary Student Health Insurance

The University-sponsored plan is voluntary. It continues to experience the enrollment of students with high risk conditions, who are uninsurable elsewhere and/or those enrolling only to use the maternity coverage.

International Health Insurance Requirements:

All International students that are here on a J-1 or F-1 Visa are automatically enrolled in the University-sponsored student insurance plan and can waive the insurance only if they have a health insurance policy that meets or exceeds SHIP's requirements. They are as follows:

- Plan must comply with all applicable ACA requirements (e.g., preventative health care covered at 100%, unlimited lifetime maximum)
- Plan must cover prescription drugs as required by the ACA
- Unlimited benefit for Medical Evacuation and repatriation
- Annual deductible less than $250/individual and $500 /family for in-network providers
- Plan must cover all sports-related injuries, with the exception of intercollegiate or professional participation
- Plan must cover non-emergency physical and mental health
- Plan must have a United States billing address, phone number and contact person
- Plan must be free of any day or visit limits.
- Plan must have in-network hospitals, physicians and mental health care providers in Salt Lake City, UT
- Policy must remain in force for the entire 2020-2021 academic year

2022-2023 Enrollment numbers by Plan Type and Period

ANNUAL
COVID19 Special Policy: 13
Continuation policy: 155
Annual Special and Subsidized Graduates Fall: 262
Annual voluntary: 791
Annual spouse and children:101
FALL
International fall: 1331
Subsidized Graduates fall: 799

Subsidized International Graduates fall: 658
Voluntary fall: 101
Fall spouse and children:126
FALL/SPRING
Voluntary Fall/spring: 114
SPRING
International spring: 27
Voluntary spring: 47
Spouse and children spring: 21
SPRING/SUMMER
International spring/summer: 1222
Subsidized domestic spring/summer: 792
Subsidized international spring/summer: 645
Special spring/summer: 62
Spouse and children spring/summer:82
SUMMER
Voluntary summer: 175
Mandatory International summer: 42
Spouse and children summer:29

Uninsured Students

We currently do not have data regarding the total number of students we see who are uninsured. We do know that the majority of those we see for sick and well visits have insurance of some type (see Healthcare section). Medicaid coverage in Utah expanded in January 2020, so those without have an additional option. While the number of insured students is encouraging, students uninsured represent a significant hardship if an illness were to befall them. The impact of potential changes such as

repeal/replace or doing nothing to the Affordable Care Act (ACA), the Healthcare Exchanges, and insurance subsidies is unknown. Students who would choose such a plan typically would have a narrow provider network and would not be seen in our center. Anecdotally, we have seen a few students who have an exchange plan, but no in network provider within the State of Utah or students who have out of state Medicaid and thus no coverage in Utah. Thus, we remain the best choice for those students due to our lower costs.

Campus Environmental Health and Safety

The Student Health Center works with the Environmental Health and Safety regarding many facets of emergency management as described in the table below:

Emergency Management Elements	**Student Health Involvement**
Communication and Warning	Campus Alert participation
Incident Management & Response	Emergency Operation Center (EOC) Operations Section
Planning	Pandemic: influenza, Ebola, coronavirus Disaster medicine Point of Distribution plan (POD) in the event of bioterrorism (e.g., antibiotics for anthrax)
Facilities	Disaster medicine planning
Resource Management & Logistics	EOC Logistics Section
Mutual Aid	County Health POD plan (see above)
Hazard Mitigation	Immunization clinics
Crisis Communications, Public Education and Information	Hospital/Campus communications GermWatch (Intermountain Healthcare infectious disease monitor) Utah Department of Health (UDOH) Epidemiology Listserv
Training and Exercises	Shakeout: Drop, Cover, Hold, Evacuate
Laws and Authorities	Incident Command System (ICS) training (online courses ICS 100 and ICS 200) *not completed by student health*

Program Administration	Staff emergency prep professional development

In prior years, this key area would include emerging disease outbreaks: H1N1, Ebola preparedness, MERS in South Korea, and the Zika virus outbreak, pandemic planning, and earthquake preparedness.

As expected, with the advent of COVID19, this area grew exponentially and took an increasing amount of the Student Health Center's Director's time. Main campus Incident Command commenced at the end of January 2020 when the first case was reported in the US, and continued to meet weekly thru mid-March when it became more structured. Initially, the Student Health Director reported virtually to the Health and Safety Committee daily, and then once the campus was largely empty on a as needed basis. Toward the end of May and into June the Director met with a taskforce to look at plans for fall testing on campus. By the end of June 2020, Incident Command structures for both the hospital and main campus were combined to facilitate communication between both University entities (they previously had a separate, but common structure with internal communication between the two groups). Under the new structure the Director assisted in the Viral Testing Domain with U Health representatives under the Health and Safety Branch to further the plans for testing on campus. As vaccines became available, the Director was then tasked into the Vaccination domain of our combined group. This Operations group of the Incident Command structure has continued to meet weekly since and is presently working on plans for the fall semester regarding the testing program, contact tracing, and a new models of HRE isolation given increasing housing demands on campus and limited isolation beds, with isolation in place being considered as a last resort.

Provide clinical training as an experiential site for nursing students and medical residents

Two of our five nurse practitioner staff are College of Nursing faculty, all of whom hold Doctorates of Nursing Practice (DNP). Dr. Pfitzner is an associate professor in the Pediatrics Department. As such, in addition to providing patient care, the SHC also functions as a site for clinical rotations for both medical residents and nurse practitioner students. A sports medicine fellow rotates with our sports medicine provider. Sixteen nurse practitioner students worked with our nurse practitioner staff for clinical experience during the 2021-2022 academic year.

During FY 21-22, using funding from the student mental health fee, the center piloted being a site for the psychiatry residents' Mental Health in Primary Care rotation. The goal of the rotation is to offer an in-clinic consultation for up to 3-4 visits with the patient then returning to their normal SHC provider for continued care, and not long-term psychiatric care. One psychiatric resident rotates with our clinic for a 6-month time period. One half day per week the resident sees patients in consultation with their attending psychiatrist who are referred by the center's providers for assistance in care (e.g. medication management, diagnostic clarification, etc.) and provides education and feedback to our center's providers. In the event a patient is considered too complex for primary care management, the resident assists our staff with appropriate referral to community resources (typically Huntsman Mental Health Institute). During the first year of this service, the resident provided 111 visits. The psychiatry residency program and our center have agreed to continue this service after this successful initial pilot.

Major Accomplishments

- Successful implementation of a COVID19 Vaccine requirement
- Piloting and continuing the Mental Health in Primary Care rotation in our office
- Successful AAAHC reaccreditation of the center

Major Challenges

- COVID19 will be with us for the foreseeable future even with the vaccine as more variants arise (in increasingly shorter time frames) and the continued need for vaccine boosters. It will continue to impact everything we do from now on -- from provision of care in the office (both actual care of this novel virus and how we provide that care thru telehealth options) to how we do outreach events like flu shots at a wellness fair. Deaths and hospitalizations have declined, yet impacts from illness continue. We are only beginning to see the long-term effects of even mild COVID19 infections on health (e.g. diabetes, increased risk of clots) as well as Long COVID. Those of us in healthcare are feeling the effects of burnout as we head into another year of COVID19. CARES Act funding which we have relied upon for testing and contact tracing goes away at the end of 2022. We do not know what we will do in January 2023. Will we consider COVID19 a "normal" endemic disease? Then campus testing and contact tracing would go away and we'd return to a model in which the health department resumes its normal role of contact tracing and testing is performed by healthcare providers. Will we need to continue a yearly requirement for COVID vaccination, or will this morph into a requirement for specific populations (e.g. annual flu vaccine for health science students)? Yet even as we look at disassembling our COVID response team we now have another emerging infection, monkeypox, to consider, learn, and plan for a response. Given our prior response, I would foresee reimagining how SHC fits within the campus and University Healthcare framework to allow us to be nimbler for future pandemics and other health crises.
- Insurance prescription benefit – Prescription drug costs are the predominate reason for rising insurance premiums. The 50% reimbursement model is not popular with students, especially those on very expensive medications. This coming year that is going up to 90% reimbursement, but students still need to pay and seek reimbursement. While we have tried to better improve education on how to be reimbursed and prevent the common issues causing less than timely reimbursement, issues remain. The cost of adding a traditional prescription benefit plan as detailed in the insurance section is a large cost increase to our policy and the majority of our students are not on routine prescription medications. This will continue to be an ongoing issue given normal cost increases and current inflationary pressures.
- Space Issues – our current location is not ideal - with no room for expansion nor in a convenient location for students. In my tenure, 2 separate Student Affairs evaluations by outside consultants indicated that our center is too small for a campus this size. Our accreditor has included consultative comments that our center is too small during each of our site visits. University leadership desires to increase enrollment toward 40,000 students by 2030. While plans are in development for a new Student Union with a health and wellness wing to consolidate the majority of the health and wellness line, how do we plan and ultimately budget for a much larger campus? We cannot just take present staffing to the new facility and expect it to still be adequate for our campus in 2030.
- Student Health Fee/funding – the student health fee ($20.48) has remained unchanged since 2011 with $3 going to the CSW once it became an independent office, and remains the lowest in

the PAC-12. We have not increased provider visits costs since 2008. As an auxiliary, we have to be able to fund our own operation. Our budget carry-forward has allowed us to modernize (e.g. EMR), remodel, and maintain fairly competitive salaries for most staff. With COVID and inflationary pressures, I foresee a need to tap into the carry forward to maintain the status quo unless we increase the fee or our cost of care (which would then likely increase SHIP premiums). This would only be magnified with a move into a larger facility. One option is to re-imagine the health fee structure, especially if timed with a move to a new facility. For example, an increase in the student fee could allow us to not charge for anything within our center (provider visits, in house lab tests). We would still need to charge/bill insurance for any radiology or laboratory specimens sent to our lab provider (ARUP). The student's insurance could then be used to cover health concerns above and beyond what is provided at SHC.

Goals (Strategic Initiatives)

Given the continued issues of limited space in our present center for a campus of this size, many of our initiatives are long-term ones that involve planning for new spaces and re-envisioning our role on campus to better serve our students. Many of these planned initiatives will need buy in from leadership and thus one goal is to communicate the history, desires, and needs or our clinic based upon previous initiatives submitted during the Balanced Scorecard Process to the new AVP of Health and Wellness. Examples of this would be better integration of our center with U Health or development of a separate immunization compliance office/health center for health science students.

In the short term, we would like to concentrate on the following initiatives:

- Anti-racism plan – we are currently trialing a program in which we incorporate readings into our general staff meetings to discuss pertinent health related topics. We are utilizing anti-racism resources from the American Association of Medical Colleges (AAMC). For example, we recently discussed "Stereotype Threat and Health Disparities: What Medical Educators and Future Physicians Need to Know"[2], which lead to a discussion about how to make our clinic feel more inclusive and some actionable items.
- Online payment – we have never had an option for the student to pay for service online and it is frequently requested on patient satisfaction surveys. We are working with our EMR vendor on an integrated payment platform such that payments made on our patient portal directly apply to the student's account (rather than just a payment button on our website that needs to them have the payments manually recorded). Number of online payments made and patient satisfaction with the survey can be our primary outcome measures.
- Improved patient portal access for lab results/notes – our present patient portal does not allow for students to access their lab results or visit notes/summaries. Providers and nursing typically send lab results via secure message to our students. Again, this is something frequently requested by our students on their patient satisfaction surveys. Our EMR vendor now has a new module that will do this and be CURES Act compliant (requires immediate release to patient once the lab is available). Implementation costs would be $7500-10,000 annually. Outcome

[2] Burgess DJ, Warren J, Phelan S, Dovidio J, van Ryn M. Stereotype threat and health disparities: what medical educators and future physicians need to know. *J Gen Intern Med*. 2010;25(suppl 2):169-177

measures can be patient satisfaction as well as measuring provider/nursing satisfaction – does this decrease or increase lab related calls? Would nursing time be decreased if they no longer needed to attached lab results via secure message?

- Maintenance of AAAHC accreditation – this would mainly be via our required 2-3 quality improvement projects we are required to do per year as well as focused chart reviews on relevant issues (e.g. adherence to UTI treatment guidelines).