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College Health Care Providers' Student-Centered Care

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Abstract

Patient care in the university setting is indelibly connected to college health care providers. College health care providers adapt to a specific set of circumstances unique to the university context in their patient care roles. The authors therefore sought to investigate the patient care phenomenon from college health care providers' lived experiences. The patient care phenomenon was explored via in-depth interviews with 11 college health care providers at universities in the Midwest and Northeast regions of the United States. The phenomenological theoretical framework of the study revealed five themes of patient care during data analysis: health education, behavioral health, student advocacy, relationship management, and reputation management. The authors designate the multi-dimensional nature of the patient care phenomenon "student-centered care" and consider practical implications for other providers who treat young university-age patients.

Keywords

Patient Care, Higher Education, Phenomenology, Health Care Provider

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Patient care in the university setting is indelibly connected to college health care providers. College health care providers adapt to a specific set of circumstances unique to the university context in their patient care roles. The authors therefore sought to investigate the patient care phenomenon from college health care providers' lived experiences. The patient care phenomenon was explored via in-depth interviews with 11 college health care providers at universities in the Midwest and Northeast regions of the United States. The phenomenological theoretical framework of the study revealed five themes of patient care during data analysis: health education, behavioral health, student advocacy, relationship management, and reputation management. The authors designate the multi-dimensional nature of the patient care phenomenon "student-centered care" and consider practical implications for other providers who treat young university-age patients. Keywords: Patient Care, Higher Education, Phenomenology, Health Care Provider

Young university students are at a critical stage of life. They must not only begin making choices about their lives that were previously managed by their parents, but they must do so in an environment that places fewer restrictions on their self-care decisions. The health habits these students develop have implications beyond minimizing preventable illness. Such habits also have implications for academic success because student illness can lead to absenteeism and impaired levels of academic performance (Nichol, D'Heilly, & Ehlinger, 2005). University-based health resources designed to foster student well-being are readily accessible, and yet students are rarely engaged with these campus resources (Lambert, 2012).

College health care providers are valuable resources because they can assist students in practical health related issues, such as re-learning coping behaviors, resisting maladaptive strategies for coping with stress, and building students' decision-making capabilities so that they can eventually become their own health advocates (Trieu et. al, 2011; Zaleski, Levey-Thors, & Schiaffino, 1998). Students have consistently ranked college health care providers among the most believable sources of health information (Vader et al., 2011). Despite the essential role college health care providers play in students' lives as advisors rather than decision-makers (Becker et al., 2002; DeMaria, 2013; Vader et al., 2011), scholars in the field of health care seem to have neglected the lived realities of college health care providers in patient care research.

The patient care experiences of college health care providers have perhaps remained unknown because of the ubiquity of empirical research in behavioral science which seeks to discover causes in order to generate explanations (Knoll, Meiers, & Honeck, 2006; McBride et al., 2010). Yet the positivistic worldview is incompatible with the constructivist philosophy that seeks understanding through examining lived realities. The expansive amount of research focused on patient care experiences of health care providers outside the university setting—primary-care physicians, osteopathic doctors, medical students, nurses, and campus mental health clinicians—(Brann, 2007; Caitta-Zuiffery & Schultz, 2012; Hathorn & Tillman, 2009;

Parry, 2003; Penner & McClement, 2008; Persson et al., 2013; Jodoin & Ayers, 2013), could also lead to the presumption of knowledge that is, in actuality, unique to college health care providers.

A focus on lived experiences of college health care providers refines the current understanding of patient care, establishes the importance of provider-patient interactions, and draws attention to the significance of patient-centered care at university. The significance of this study is the increased understanding of the life world of college health care providers.

Misunderstanding college health care providers' patient care experience holds several practical implications. Providers might not receive funding for treatment protocols and interventions if university administrators do not know what disorders are unique to the student population (Trieu et al., 2011). Students could pursue services outside of campus that they do not know are a standard part of the health center visit (Swinford, 2002). Lamenting the lack of benchmarking data on student health centers, McBride et al. (2010) stated the matter succinctly: "Better information is needed to understand the contribution of SHS to young adult health care services as well as for campus health service planning and administration" (p. 2).

To address the current gap of knowledge in this area, the present study began with a review of studies in which researchers examined health care provider experiences to capture the meaning of patient care. Next, the authors investigated the lived experiences of 11 United States (U.S.) college health care providers, providing a foundation from which to understand the essence of patient care. At the conclusion of the study, the authors situated findings within the larger body of knowledge, and made recommendations regarding practical implications for health care providers.

Literature Review

The authors conducted a thorough research review in order to gather evidence about the study phenomenon—how college health care providers experience patient care. The authors employed a thorough search strategy comprising Science Direct, Google Scholar, and JSTOR academic online electronic databases for the years 2005-2016 inclusive. They combined the keywords "university OR college" and "health care provider" for searches by relevance in journals. They added the search terms "student" and "center" in order to narrow the search. Finally, they noted the philosophical worldviews from which the subject matter has been investigated in order to provide more of a critical appraisal of the evidence in the literature.

The phenomenon of study—how college health care providers experience patient care—is severely under-studied. The authors identified just five research studies exploring the study phenomenon (Alschuler, Hoodin, & Byrd, 2008; Campbell, Auerbach, & Kiesler, 2010, Jozkowski, Geshnizjani, & Middlestadt, 2013; Neinstein, 2000; Trieu et al., 2011). College health care providers were the sole study participants in only three of the identified studies (Jozkowski, Geshnizjani, & Middlestadt, 2013; Neinstein, 2000; Trieu et al., 2011) and comprised a small minority of participants in the remaining two studies (Alschuler, Hoodin, & Byrd, 2008; Campbell, Auerbach, & Kiesler, 2010). Additionally, the authors noted that the mode of inquiry included experimental, survey, and interview research. Despite limited scholarship, authors of the present study noticed two distinct focal areas of provider patient care research: Societal barriers hinder their care capabilities and the significance of provider-patient interactions.

Scholars have determined that societal norms regarding sexual health were barriers to patient care. Jozkowski, Geshnizjani, and Middlestadt (2013) interviewed campus healthcare providers regarding their perspective on promoting preventive sexual health behaviors. Providers indicated that patients are sometimes uncomfortable with visits regarding health issues. These providers also stated that building rapport with patients is effective in fostering

open dialogue possibly "minimizing the extent to which patients might view sex as taboo" (p. 27).

Social barriers to sexual health care were also evident when Trieu et al. (2011) surveyed California community college health provider's provision of emergency contraception. According to providers, the cost of emergency contraception was a result of state funds being differentially allocated to select health services. Some community college students were simply unable to afford the price of emergency contraception. Another barrier was (potential) lack of awareness: Fewer than half of the providers surveyed promote emergency contraception on their health center websites because of societal assumptions about overutilization. Barriers notwithstanding, the providers noted that websites could be an effective means of bridging the digital divide between providers and their students. Providers reported likewise in survey research by Neinstein (2000).

Neinstein (2000) conducted online survey research with American College Health Association (ACHA)-affiliated universities to examine the potential benefits and drawbacks of electronic communication with patients. The significance of provider-patient interactions emerged in study results as an essential aspect of the patient care experience. Electronic communication has been particularly helpful facilitating patient interactions, according to providers. Providers listed incoming emails from patients, announcements about general health center information, and outgoing messages such as emails to patients studying abroad.

Provider-patient interactions seemed a foremost concern when Alschuler, Hoodin, and Byrd (2008) assessed the need for integrated campus health care, wherein students could visit doctors and therapists in the same facility. Their experimental research involved a behavioral questionnaire for student-patients and pre- and post-visit surveys with patient and providers. Providers noted benefits and drawbacks to the patient questionnaire: On the one hand, it reminded providers to discuss patient concerns, even making such concerns easier to discuss. Conversely, the questionnaires added time to patient visits. Providers were amenable to collaboration with co-located behavioral specialists.

Campbell, Auerbach, and Kiesler (2010) noted the significance of provider-patient interactions when they evaluated how providers presented information and involved patients during routine visits. Study findings indicated that providers helped patients participate to a high degree during consultations. For providers, satisfaction with patient care is influenced in part by the manner in which they relate to students. The scholars assert that college health care providers should be alert to patient preferences in order to adapt to them.

Taken together, the aforementioned studies provide a fragmented view of the patient care experience. Part of the issue is functional, in that the studies are restricted by their methodology (small participant size). In this study, the authors expanded the lens through which to view patient care by examining the experiences of college health care providers from providers' lived realities.

The purpose of this study was to explore college health care provider experiences caring for patients in the university setting. Study findings could aid scholars by expanding upon the patient-centered model of care (Lorig, 2012; Rickert, 2012) to construct a student-centered approach to health care. The central research question for data collection and analysis follows:

RQ: How do college health care providers experience patient care?

The authors adopted the phenomenological theoretical tradition, described in the next section, to gain insights into the realities of patient care from the perspective of college health care providers.

Method

Phenomenology

The theoretical framework for this study is phenomenology, a system of ideas associated with Edmund Husserl, Martin Heidegger, Jean-Paul Sartre, Maurice Merleau-Ponty, and Alfred Schutz (Denzin & Lincoln, 2011). Phenomenological scholars seek to understand lived experience and social actions—phenomena—from individual perspectives (Creswell, 2013) by uncovering the logic inherent in human experiences (Dukes, 1984). Phenomenology enables scholars to understand sense-making frameworks by capturing the essence of an experience through close examination (Starks & Trinidad, 2007). The goal of phenomenology, then, is to clarify meanings.

Participants

Phenomenologists collect data from persons who have experienced a particular phenomenon (Lindlof & Taylor, 2011). The authors used *purposive sampling* to draw the population of study:

> Purposive sampling strategies are designed to enhance understandings of selected individuals or groups' experience(s) or for developing theories and concepts. Researchers seek to accomplish this goal by selecting "information rich" cases, that is individuals, groups, organizations, or behaviors that provide the greatest insight into the research question. (Devers & Frankel, 2000, p. 264)

Therefore, the authors selected college health care providers as the population of study because of their knowledge about patient care and their shared status within a subset of the larger health care community.

The first author selected college health centers located in two cities, one each in the Midwest and Northeast region of the United States. Together, the authors located complete lists of colleges and universities on official city websites. The authors then searched individual university websites to identify campuses with student health centers in order to compile contact information for each center. The final list comprised college health providers at 35 health centers. Providers at all 35 health centers received individual e-mails which included a study description and invitation, an Institutional Review Board-approved informed consent document, and an interview guide (see table 1). The authors sent one follow-up email and, depending on response, one follow-up telephone call to all 35 providers to request participation. Eleven providers from nine university health centers agreed to participate (see table 2).

Data Collection

In general, studies that draw upon a phenomenological approach gather data via in-depth interviews and personal documents (Creswell, 2013). Researchers can discover details about study participants' lives with interviews, especially if the interview starts with biographical questions (McCracken, 1988). The first author developed the data collection instrument, an interview guide with a semi-structured design (see table 1) adapted from Anfara, Brown, and Mangione (2002). The interview questions prompted follow-up discussion (Castillo-Montoya, 2016). The follow-up discussion between a researcher and study

participants is vital to phenomenological inquiry because it allows for the co-creation of knowledge.

Table 1: Interview guide

1. Please describe in your own words what it's like to work at the health center.
2. Can you tell me what happens during a typical work-day?
3. How closely does the health center work with other college departments or other faculty or staff at your university?
4. What percentage of this university's students would you estimate use the programs and services at the health center?
5. Are these programs and services available to those who are not students?
6. Besides maintaining the health of student patients, what do you believe is the primary contribution health centers should have to the campuses where they are located?
7. How has the nature of the relationships between health centers and students changed in the past five years—either at your center or in centers across the country?
8. How do you foresee the relationships in the future compared to how they are now?
9. Reports indicate that new and social media have affected many health and medical providers, patients, and employees—not always in a good way. How have new and social media affected health centers as a whole?
10. How have new and social media affected the interactions between health centers and students?
11. How has your health center responded to this new media trend? (Online appointments, Web-MD referrals, clinic blog, etc.)
12. In general, what image do you believe health centers have?
13. In particular, what image do you believe your health center has?
14. Is there anything else you would like to add that we have not covered?

Face-to-face is the best technique for conducting long interviews (Strauss & Corbin, 1998), so the authors scheduled in-person, individual interviews in summer 2012 (Midwestern U.S. providers) and spring 2013 (Northeast U.S. providers). All participants read, signed, and received a copy of an informed consent statement with study details at the start of each interview. They agreed to have their interviews digitally recorded, so the first author audio-recorded each interview. In keeping with suggestions for extensive researcher/participant interactions in phenomenological studies to establish shared understanding (e.g., Dukes, 1984), each interview lasted at least one hour. The authors conducted the interviews at participant workplaces. Although the first author hired a professional service for interview transcriptions, she reviewed the completed transcripts carefully to ensure that they accurately depicted participant constructions.

Table 2: Profiles of respondent's health center universities

Respondent No.	Region of the U.S.	Location
1	Midwest	Large university (<15,000 students)
2	Northeast	Medium size university (5-15,000 students)
3	Northeast	Large university (<15,000 students)
4	Midwest	Large university (<15,000 students)
5	Northeast	Small university (> 5,000 students)
6	Midwest	Small university (> 5,000 students)
7	Midwest	Small university (> 5,000 students)
8	Midwest	Small university (> 5,000 students)
9, 10, & 11	Northeast	Medium size university (5-15,000 students)

Data Analysis

Because the researcher is the instrument in qualitative research (McCracken, 1988), the authors analyzed the study data, the interview transcripts. They utilized Creswell's (2013) multi-stage phenomenology analytic approach. Each of the stages is described next, accompanied by corresponding evidence from the interview transcripts.

Personal experience with patient care. In the first stage of analysis, the first author described personal experiences with the phenomenon under study so that the focus could be directed to study participants. Phenomenological researchers acknowledge assumptions regarding the study phenomena to *bracket* them—set them aside—to prevent preconceptions from hindering understanding of participant experiences (Creswell, 2013). It was while I, Cheryl Ann, earned my doctorate, that I first became interested in college health. My secondary area of study was health communication, so my doctoral studies included ethnographic research on a team exploring freshmen student perspectives on weight. That interest continued as a result of my dissertation research, where I studied the meaning of health to female undergraduate students. It was during my dissertation that I came to realize that students formulated perspectives about campus health centers based on little direct contact. I had experience with college health centers as a scholar and a patient at the time of my doctoral program. My interactions with health centers shifted when I began working as an assistant professor.

As an assistant professor, I served on an alcohol task force to raise awareness about misuse of alcohol and I volunteered with student health educators as part of my academic service. As a scholar, I have conducted research about the campus culture as a factor in student health. Scholarly research consistently revealed a disconnect between the quality and perception of service in student health care. Thus, I initially set out to investigate how college health care providers viewed the image of health center centers. I noted early on during data collection that I held a distorted view of health centers. In fact, perceptions of health centers were low on the list of provider concerns. Rather than situating this study around *a priori* ideas, I reconsidered the data seeking to understand providers from their own perspectives. As a result of this realization, I de-centered my outsider *etic* perspective I had gained from reading and research to better facilitate providers' insider, *emic* perspectives (Daymon & Holloway, 2002).

Significant statements of patient care. In the next stage of analysis, depicted in table 3, the authors carefully read the interview transcripts to identify statements in which providers described their patient care experiences. Then, they used a separate document to compile a list of the statements.

Table 3: Significant Statements of Patient Care

R: Line	Patient care statements
1: 62-68	Reassure student-patients who are unduly worried
1: 142-143	Feeling stretched in terms of meeting services with resource limits
1: 710-713; 725	Conduct service recovery survey
1: 786-790	Explored feasibility of continuity of care
2: 82, 100 & 102	Interdisciplinary campus connections
2: 166-170	Some student-patients will go home to their primary care physicians
2: 365 & 385	Treating the "worried well"
3: 107	Making health integral to campus community
4: 490 & 500	Help student-patients make good choices/do not overwhelm
4: 662	Asked outside lab for equipment donation
4: 774	Refer student-patients to good websites

4: 963	Noticing older students caring for parents
5: 47-54; 76	Noticing health center location not as accessible as it could be
5: 348-353; 374-338	Grateful for interdepartmental support
5:438	Provide flu clinics for students, faculty, and administrative employees
6: 31-35	Offer classes on exercise, weight management
6: 125-129	We work closely with other campus departments
6: 165-169	Provide care to students, faculty, and staff at nearby colleges
6: 401-402	Posting pertinent health information on health center website
7: 481-482	Contrast from off-campus patients who never Google symptoms
8: 16	Deliver guest presentations at residence halls
8: 419-423	Participate in H1N1 emergency planning
8: 469	Collaborative "early alert system" to assist students in crisis
10: 75-77	Taking the time to treat full patient
11: 121	Offer consulting to faculty via presentations

Meaning units of patient care. The next stage of analysis is depicted in table 4. During this stage, the authors re-read the list of significant statements for classification purposes. They organized the statements into units of meaning.

Table 4: Meaning Units of Patient Care

Respondent-No.	Patient care (line number)
R-1	Being shadowed by internal medicine students (767)
R-2	Engaging in multidisciplinary campus connections (82; 100; 102)
R-2	Interacting with protective parents (276)
R-2	Treating the "worried well" (365 & 385)
R-3	Becoming a medical home for students (107)
R-4	Making health integral to campus community through outreach (374)
R-7	Overcoming misperceptions of center capabilities (206 & 340)
R-9	Demonstrating compassionate care beyond center walls (174)
R-10	Preparing students for health care decision-making as they transition to adulthood (65-67)
R-11	Embodying a holistic approach to care (117-121)

Thematic clusters of patient care. In the next stage of analysis, depicted in table 5, the authors reviewed the meaning units for further classification. They sorted the statements into larger categories by theme.

Table 5: Thematic Clusters of Patient Care

Thematic clusters	Patient care (line)	Respondent-No.
Providers employ multiple health education techniques to facilitate campus-wide engagement in student health care	Being shadowed by internal medicine students (767)	R-1
	Engaging in multidisciplinary campus connections (82, 100 & 102)	R-2

	Making health integral to campus community through outreach (374)	R-4
Providers prepare students for making their own health care decisions post-college	Treating the "worried well" (365 & 385)	R-2
	Preparing students for health care decision-making as they transition to adulthood (65-67)	R-10
Providers employ student-centered model of patient care	Becoming a medical home for students (107)	R-3
	Embodying a holistic approach to care (117-118)	R-11
Providers acknowledge parental involvement in patient care	Interacting with protective parents (276)	R-2
	Demonstrating compassionate care beyond center walls (174)	R-9
Providers encounter erroneous assumptions about college health care	"We don't treat them and street them" (119-121)	R-11
	Overcoming misperceptions of center capabilities (206 & 340)	R-7

Textural description of patient care. The next stage of analysis is depicted in table 6. In the textural description stage, the authors re-read the data, highlighting verbal illustrations of each category. They used verbatim examples to describe the patient care phenomenon from providers' perspectives.

Table 6: Textural Descriptions Patient Care

Textural descriptions	**Patient care (Respondent No. Line No.)**
Providers employ multiple health education techniques to facilitate campus-wide engagement in student health care	Attending new student orientation while wearing lab coat (R4.229 & R4.374) Passive presentations like stall news, etc. (R8.308; 314; 371) Early Alert program (R8.469) Faculty service chats (R6.156-159)

Providers prepare students for making their own health care decisions post-college	"A lot of times there's a lot of opportunity to help them because they are just sort of formulating…it's the first time they've encountered health care on their own" (R10.65-67) "I said 'you are going to die'" (R4.516) "They can hardly articulate what's wrong" (R7.26)
Providers employ student-centered model of patient care	Requesting sliding fee from endocrinologist (R4.1033) Recognizing that informed, interested, intelligent students might utilize inaccurate online information (R1.538) After four months of letters and emails to student; finally reached through text (R5.982-990)
Providers acknowledge parental involvement in patient care	FERPA & parents/email compliance (7.510 & 535) "He's so busy, can I just come in?" (R2.276) Extensive calls with parents (9.263)
Providers encounter erroneous assumptions about college health care	Retired doctors used to go to health center to conclude their career (R1.759-760) "Band-Aid station" (R7.206 & 340) "Not the 'Infirmary'" (R3.244)

The final two stages of analysis are listed next in the *Findings* section because they represent the culmination of the analytic stages.

Findings

In the *structural description* stage of analysis, the authors reflected on the contextual setting of the patient care phenomenon. They developed the following section by situating the patient care phenomenon as a lived experience of college health care providers.

Structural Description of Patient Care

In the university context, patient care necessitates functioning within the natural ebbs and flows of the campus environment. The percentage of student-patients might vary from one health center to the next, but the fall semester is typically the busiest. Thus, flu season draws a seasonal uptake in center visits for vaccines. A surge of international students for

immunizations is also typical in the fall semester, as is an influx of Study Abroad students preparing to go overseas in the spring semester:

> In the fall, we come in and you just get swamped with international students who are coming in and who have to be evaluated before classes start in a short period of time. And then…kids with serious medical problems wanting to touch base with the health center and find out more and so on. So the first couple of weeks in the fall are very busy, meeting with parents who happen to be on campus and with new students. For whatever reason, fall tends to be busier than spring (R#1).

The academic environment means working in close proximity to departments such as Residence Life, Health Education, Campus Police, and the Counseling Center. Religious-affiliated institutions might also interact with the college chaplain. Providers meet with colleagues from across campus either case-by-case or regularly. Inter-campus connections are especially important during public health emergencies, according to R#5; Respondent #2 meets daily with the athletics department because health center providers treat intercollegiate athletes.

College health care providers have to be able to call upon internal and external resources during outbreaks of measles or H1N1:

> Usually the kid who's got the flu we're sending home, but right now we have a student from Florida who's in his room. He can't go home and he's sick. I don't want to move him. I feel like the other student should be able to move if they feel threatened. The truth is that you can be exposed to flu 48 hours before you get symptoms. Therefore, you know, moving them [doesn't work because] they could've already been exposed (R#9).

College health care providers employ multiple communication vehicles. Many respondents reported using Email, E-newsletters, Facebook, Flyers, Patient satisfaction surveys, Posters, Presentations, Secure electronic portals, Telephone, Text, and Websites. The management structure of college health centers varies from one to the next. However, providers experience the problems that beset work groups that operate within larger organizations such as bureaucratic decision-making and too great a focus on individual pet projects. Some health centers are led by nurse practitioners with periodic visits from physicians; others have medical doctors working full-time as directors with a sizable staff of both doctors and nurses handling patient care. Staff variations can occur based on whether or not a center has a third-party-billing model, or network limitations of visit numbers, size of deductible, or coverage.

Health centers are typically open only to full-time students, and some of those students pay a nominal health fee. Budgetary restrictions are a fact of life at health centers, so providers are especially grateful when they receive financial support. Respondent #4 seeks assistance outside the university to supplement health center resources: "In fact, I just sent off a letter to a company to see if they would donate a piece of lab equipment because there is no way that I can buy it."

College health care providers tailor their patient care approach as necessary. Respondents educate themselves about particular cultures for service encounters with international students, for example: "Let's say we have some Middle Eastern, Islamic students. What's a taboo for them? What do they feel comfortable about doing (R#5)?"

Other providers utilize electronic resources to locate up-to-date information about health concerns. Seeking information online is not always deemed appropriate provider behavior, however. According to R#1, a survey respondent described the provider as

"unprofessional" for looking something up on WebMD while she was in the room during a patient visit.

College health care providers have to manage student expectations as it relates to visit duration, wait-time, and outcomes. Health center hours might vary from one to the next with periodic adjustments according to visit frequency and staff availability; in fact, there is no clear agreement about the merits of appointment vs. walk-in scheduling.

Composite Description of Patient Care

For the final stage of analysis, the authors wrote a composite description of the patient care phenomenon. To write this section, they combined patient care information from the textural and structural descriptions. Then, the authors used respondent words to develop a detailed description of their patient care experience. The composite description represents the essence of the patient care experience.

Patient care is health education. The most gratifying aspect of being a college health provider, according to R#3, is when patients understand the information providers convey. Providers in this study tailor their information approach according to the most effective means for reaching students. Respondent #4 employs a multi-channel strategy, writing a monthly article for the campus-wide electronic newsletter, tracking news coverage of health issues that could impact the campus community, and distributing information about seasonal illnesses to faculty, staff, and students. Other providers deliver presentations in residence halls:

> When I do the dorm presentations [about sexual health and behavior] I always take lots of condoms, and if people don't take them, I just leave them there and the RA will give them out for me. It's just so much easier when you have something you can give to [students] so they don't have to act like they're interested or be embarrassed or anything (R#8).

Respondents also facilitate student access to credible online health information. One center has added links on its website to reputable health information sites; another center provides lists of credible websites when delivering presentations to dormitory residents. Respondent #5 updated website messaging about emergency contraception when the health center reduced its weekend hours:

> The longer you wait [to use emergency contraception], the less likely it is to be effective. So if you had unprotected sex, let's say on a Friday, it is much better if you take your emergency contraceptive on Friday than wait until Monday (R#5). Information about weekend hours and emergency contraception was added to its website (R#5).

Staff at Respondent #5's health center also provided additional in-person messaging via training with resident assistants.

One provider utilizes passive means to facilitate health information outside of the health center. Respondent #8 uses a weekly *passive presentation* to promote various health issues with signage and related handouts at a table in front of the campus dining hall. Center employees sometimes hang a banner or use table-tents to deliver information in the dining hall. The presentations provide access to information students might not ordinarily seek out. Their location and week-long timeframe facilitates low-risk, low-pressure health messaging.

Health education is a critical component of the patient care experience for college health care providers. Providers might help students understand whether a specific body change is

normal or requires medical attention. These providers also provide details about treatment options to students who are sometimes unnecessarily worried about the gravity of a health issue:

> Many of the students who come in think that whatever is wrong is just the end of the world for them. And it is most commonly something that you can really help with, something that is going to be self-limited and you can reassure them that they're going to get better anyway. Or it's something that you can really substantially help them with and you know they're going to get better (R#1).

> People get very nervous about stomach things, stomach pain for example. It turns out, even if you're going to rupture your appendix, it takes 24 hours. So it turns out that you can be really sick with a bad stomach, but there's really nothing to do…So you can give them reassurance (R#5).

Other misconceptions that providers encounter are inevitable. Health centers at religious-affiliated institutions are staunchly pro-life and anti-abortion, so, according to Respondents #2 and #7, students and faculty periodically will vocalize their displeasure at the center's lack of birth control options. Providers have to be able to explain that such fights are not with the health center, but with the institution's core values. These providers must correct erroneous assumptions about providing sexual health advice. Multiple channels and frequent messaging to correct misperceptions are among the approaches respondents use:

> "You can't go there to get your pap" gets translated many times by students into "They don't treat sexually transmitted diseases." We don't distribute birth control pills and we don't have morning-after pills here, but I teach them all about it and tell them where they can get them free (R#7).

Combining messaging platforms has been most effective for Respondent #2, whose health center is located at a Catholic university. This respondent makes advice the focal point:

> We don't have condoms; we don't give out birth control… [but] we do all kinds of STI testing and advice. When you're talking to me and we are in an exam room, we give you good advice. I can't hand you a condom but I will give you an update. That's on our website and we try to publicize this (R#2).

Patient care is behavioral health. Although mental health services are not the sole purview of college health centers, providers indicated that counseling occurs naturally during the patient care experience. Respondent #9 attributes the regularity of such discussions to the decrease in societal barriers to mental health care: "I've seen students much more comfortable to mention mental health issues and that's for our office as well as counseling." The ability to speak freely about mental health might be why providers like Respondent #4 are treating "a lot of students with mental health and chronic physical illness." However, caring for patients with certain mental health issues pose a particular challenge, as illustrated in the following quotation:

> A student I know to be eating disordered had a contract with her provider that she had to maintain a certain weight or she couldn't stay in the residence halls…She came in to be weighed, and five minutes later stormed out, furious, after being weighed…She was pissed that she had a pound more on than she

needed to stay in school. Eating disordered students are usually quite good students academically [so] they're our most challenging students (R#5).

Respondent feedback suggests that the benefits of counseling far outweigh the challenges involved. Students and faculty view the health center as a "safe place" according to R#4, who has witnessed faculty bringing students in who need immediate care. Such care can be critical for college students in crisis. Respondent #2 provided a poignant statement on the impact of counseling in patient care:

> I think we have prevented kids from falling through the cracks. I can honestly say I think we have prevented deaths, I think we have prevented suicides with this combined approach where we're identifying risk very early on and identifying these kids and keeping them healthy before they get to that point (R#2).

Providers appear to be taking an inclusive approach to patient care, giving equal time to students physical and mental health concerns. Respondent #9's vision of college health is to provide health services and counseling from the same building, and to oversee health promotion, alcohol prevention, health nutrition, and spiritual life. "We can offer all of this, the whole mind-body connection, to students and services that treat them when they're ill but also help them prevent illness when they're well and live a more balanced life in the future (R#9).

The half-hour visits at the health center where R#2 is employed fosters integrated care: "We don't 'treat them and street them' which means you get them in, you take a throat culture, hand them a prescription, and kick them out. We're looking at the whole patient." Study results suggest that counseling naturally occurs from holistic patient care.

> We try to look at the social aspects and their habits and their lifestyle in addition to what they came for that day. It is not unusual that they're coming for a cold but we end up talking to them about something that happened at home with their family or a roommate issue or a substance abuse issue (R#10).

Patient care is student advocacy. For several respondents, advocating on behalf of their patients is a part of the patient care experience. Their advocacy requires taking a long-term view of student health, and it is a responsibility providers take seriously: "Part of what we're doing is we're helping to grow future leaders, our future citizens, our current citizens. Helping them grow to be very well-rounded which includes their health" (R#6). According to R#3, college health care centers should be a bridge between the kind of health care students received back home and the care they will receive once they graduate from college:

> Our job is as much taking care of their medical needs as it is helping them transition to a medical or an adult model of health care, realizing that some of these students are coming in and trying to navigate the health care system for the first time on their own (R#7).

In addition to keeping students healthy and in class, Respondent #8 said providers must foster healthy habits among students, which include imparting messages about social responsibility.

> You can't totally rely on them 100 percent to manage their illness and then you have the parents who are worried, or the kid who doesn't want to tell their

parents. What do we do? We encourage them to let us talk to their parents so that we…you know, we say, "Might your parents be worried about you because you're so sick?" and usually they'll allow us to do that (R#9).

College health care providers demonstrate advocacy by drawing upon external resources to improve patient care. For example, respondent #2 keeps appraised of public health issues outside the campus:

We're on the conference call with the Department of Public Health. I always get in on them. Most colleges don't; there are usually one or two colleges on the call…It's great because they go through what they're seeing and what's really affecting older people and younger people.

Respondent #7 said health center employees meet weekly with doctors to determine whether a team-based service approach is necessary: "We do a lot of consulting with each other. We always collaborate…we always talk to each other about our cases." Respondent #6 developed a promotion-based program, partnering with the campus chef for healthier options in the university dining hall:

We've worked with [our chef] to change some of the offerings so that now there's at least two vegetables offered every day. They have an endless soup and salad bar now, and some other initiatives like that that will impact student choice by having it available. We're working with [the chef] to promote that (R#6).

The program will include face-to-face interactions with the chef to promote special lunch options. Diners can ask about how to fix healthy foods; the chef can explain how students can integrate fresh fruits and vegetables into their daily lives.

Patient care is relationship management. Respondents indicated that patient care requires relationship management. It is essential for providers to earn student trust in a very brief timeframe to be effective caregivers.

In the private practice after you have been there a while you build up a rapport with your patients…They come to you with the expectation that you know what you're doing and they know you are competent. In the case of college health, the first time you see somebody, within about five or 10 minutes, you have to establish that you care about them and that you know what you are doing (R#4).

Relationship management can occur gradually following a longstanding chasm between providers and patients. For example, respondent #5 initially did not understand why patients complained when, as part of standard service visits, providers asked if they were pregnant. The provider finally discovered the sources of complaint: Gay students were upset that someone should assume that they were heterosexual; students who did not have sex were upset at what they deemed was the presumption of promiscuity.

According to respondent #5: "We made a big, concerted effort, for a number of years, to say, 'When was your last period?' and not ever to say, 'Can you be pregnant?', unless their last period was, say, three months ago." Provider-student interactions have improved because of the change.

Sometimes, respondents must manage strained relationships between students and their parents as a result of Family Educational Rights and Privacy Act (FERPA) and the Health

Insurance Portability and Accountability Act (HIPAA) policies. When students do not sign a waiver to allow their parents to know their health status, providers face the brunt of parental backlash. If a parent calls the center about a recent visit of his daughter, for example, the provider might have to explain that his daughter has not given consent for parental access to her medical records.

Other times, students effectively invite their parents into their appointments via cell: "I'll leave the room and come back and they've got mom on the phone and I have to explain what I'm doing or not doing (R#7)." The most challenging parent interactions occur when students complain to their parents about a center visit in which they did not understand provider feedback:

> Sometimes they come in, and you spend what you feel is a long amount of time with them explaining the line of medical reasoning that you're following…And then they just get right outside the door there and call mom, and our phone's ringing and it's mom wanting to know what the heck kind of operation are you running there (R#7).

Patient care is impression management. Health center reputation emerged as an aspect of patient care among college health care providers in response to negative perceptions about health centers. Respondent 5 shared a memorable student comment from a customer service survey: "One year, [a student] said as a complaint, 'I was sick when I got there, and was sick when I left.'"

Unfortunate labels that Respondent #7 encounter range from assertions that the providers are not real doctors—which R#7 deems are a likely holdover from 70s-era infirmaries run by retired family doctors who saw students on a voluntary basis—to the "Band-Aid station."

> When, in fact, the providers here are all Advanced Cardiac Life Support certified. Most of us have worked in the emergency department or some other critical care background. We do sutures. We take off warts and moles. We function very much like a regular doctor's office, but somehow this, there's still kind of this lingering perception that, "well, I go there but not if I'm really sick" kind of thing (R#7).

Respondents utilize different approaches to counter negative perceptions. "One of the things that I find really sort of rewarding and make a goal is…to make that first experience a really positive one and to sort of allow them to have that view of the health care system" (R#10).

Respondent #1 uses negative customer service surveys for service recovery: "If somebody discusses a negative experience that they had and gives their contact information, I'll usually make contact with them and try and correct whatever I can about their experience (R#1)." Invoking humor has been helpful for another provider:

> Every year, like a joke, you know, when I talk to RAs or something like that, I say, "Oh people always ask do we have real doctors at the health center," and I always say, "No, no, we have fake doctors" (R#5).

Providers have a direct hand in the reputation of the health center by adjusting policies to benefit specific patient care concerns. One such example occurred regarding the policy for providing, or not providing, students with doctors' notes to excuse them from class:

The professor knows it's not my right to say, "You have to excuse this kid." I may talk to the professor. For instance, I have a student who's getting chemo for cancer. I may say to the professor, "You know, this has been a particularly bad week. This kid's been in bed all week vomiting because of chemo. If you can give him a little extra consideration, I'd appreciate it." That's it (R#9).

In many ways, impressions management seems to be an outgrowth of improvement in the quality of care delivered. According to R#3, some college health centers deliver "care that rivals what would be delivered in the community." This respondent credits the health center staff:

We are staffed by people who are committed to caring for college students. I mean this obviously isn't true everywhere, but I feel like the people who I have here currently really want to be here, they really want to be taking care of college students. They are here because they choose to be here (R#3).

Respondent #1 has also noticed an improvement in perceptions outside the university:

I would have people I knew who worked in the emergency rooms or in various specialty clinics in town coming in and saying "Oh my God, we don't have students coming into the emergency room anymore. We used to see 20 patients every night from here because kids were just afraid to go to the health center. We just don't see anywhere near the volume of students from the health center anymore" (R#1).

Discussion

By employing a phenomenological approach in this study, the authors sought to convey respondent realities through the specific language college health care providers use to articulate their patient care experiences. While there is no typical day for a college health care provider, similarities do exist in the ways they experience patient care. Study findings reveal patient care in the university setting to be complex and multifaceted; depending on the context, it might involve health education, behavioral health, student advocacy, relationship management, or reputation management. Findings from the present study add to the limited body of knowledge about the study phenomenon.

Respondents' views on the importance of health education in patient care hold similarities to previous research. In Alschuler, Hoodin, and Byrd (2008), pre-visit patient questionnaires fostered *provider* education about patient concerns. Conversely, *patient* education was the focus in Neinstein (2000): Electronic communication was an effective means of sharing health center information with patients who were off-site. Of additional interest is the fact that barriers to sexual health education reported in the present study correspond to findings from Jozkowski, Geshnizjani, and Middlestadt (2013) and Trieu et al. (2011).

Only one provider in the present study made overt mention of the integrated care model that Alschuler, Hoodin, and Byrd (2008) recommended. Nevertheless, it was common for respondents to encounter behavioral health issues during non-related patient visits. According to scholars, behavioral problems were insufficiently explored in standard university health care practice and college health care providers were amenable to co-located behavioral specialists. Alschuler, Hoodin, and Byrd identified other potential benefits as well: "Addressing more

mental health issues may result in cost-savings to the university and improved student retention" (p. 392).

It was surprising that, despite the expressed importance of preparing young students for adult health care, the authors were unable to find previous scholarship directly linking student advocacy to patient care. Perhaps college health care providers have not fully embraced the idea of advocating for their students the way they would have to in family or community practice. The study by Trieu et al. (2011), points toward advocacy, however. Providers seemed to serve as advocates for low-income students when they attributed the high cost of emergency contraception in California Community Colleges to unfairly allocated state funds.

Effective management of provider-patient relationships has been a recurring theme in the literature, with Campbell, Auerbach, and Kiesler (2010) asserting that how providers relate to patients determines student satisfaction. Results of the present study also correspond to Neinstein's (2000) findings: E-communication has helped facilitate provider-patient interactions. Study results regarding provider-parent interactions suggest parental involvement should be considered in the relational dynamic.

As with the present study, impression management was a factor when Jozkowski, Geshnizjani, and Middlestadt (2013) explored providers' perspectives on preventive sexual health. By fostering open dialogue with anxious students, these providers are managing patients' impressions of a fraught topic. Respondents in the present study noted likewise when they deliver sexual health lectures at residence halls, and then leave condoms afterwards for students who did not attend. In some instances, context-based barriers to sexual health preclude impression management in college health care. Study respondents at religious schools are not allowed to provide certain health services. Providers at California community college health centers are restricted by high-priced contraceptives due to societal assumptions about overutilization.

Centering the Patient in Campus Health Care

Providers who practice patient-centered care work in consultation with their patients; Patients are the sole determiners of effective care.

> Patient-centered care is a method of care that relies upon effective communication, empathy, and a feeling of partnership between doctor and patient to improve patient care outcomes and satisfaction, to lessen patient symptoms, and to reduce unnecessary costs (Rickert, 2012, n.p.).

Building upon the idea of patient-centered care, the authors propose a new *student-centered care* model to encapsulate respondents' patient care experiences. Respondents invite students to play an active role in their own health care to foster patient autonomy, consistent with Campbell, Auerbach, and Kiesler (2010). DeMaria's (2013) assertion about millennials' preparedness to navigate the health care system as adults was also evident in the present study.

Another aspect of student-centered care in study findings was the holistic approach that respondents employ. Respondents demonstrate preparedness to adapt to the socio-cultural shifts in the patient population, ably responding to unanticipated student questions (Dellande et al., 2004). Like Trieu et al. (2011) and Neinstein (2000) found, respondents also noted that websites could be an effective means of bridging the digital divide between providers and their students.

Lorig (2012) identifies some noteworthy aspects of patient-centered care in health education. Considering the extensive clinical and academic resources study respondents have

at their fingertips, the academic setting seems an ideal environment for the proposed model of student-centered care.

Limitations and Future Research

The present study is one of a handful in the specific area of college health care providers' patient care experiences. Thus, study results lay the groundwork for an under-studied phenomenon. The patient care experiences of study respondents could differ from other college health care providers, which some readers would consider a limitation. However, phenomenological scholars seek understanding of a few individuals who have experienced a given phenomenon (Starks & Trinidad, 2007).

College health care providers can utilize insights from study results to explore student perspectives on the proposed student-centered model of care. Health care providers outside the campus environment might benefit from implementing some of the strategies respondents employ. Given the complex guidelines within the U.S. health care system, providers could educate patients about the intricacies of health care, thus positioning themselves as advocates and caregivers. Providers could very well see an improved reputation as a result of such efforts.

Future research in the area of college health could include an exploration of patient care from a critical/cultural studies tradition to uncover how provider-student power dynamics inform their interactions.

Conclusion

College health care providers ascribe specific meanings to the patient care experience. Their occupational roles extend beyond the boundaries of the bio-psychosocial model of care. Providers encounter patients who are transitioning from adolescence to adulthood. Their responsibilities typically involve assisting patients with health care decision-making. As educators, providers use multiple channels to disseminate health messages. The patient care experience they describe includes managing healthy boundaries between patients and their parents. It also necessitates deft handling of problematic interactions. College health care providers work closely with other departments, exchanging patient information when students are in crisis. Results of the present study suggest that empathic interactions are the foundation to effective university-based patient care.

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