

Faculty and Staff Health Promotion: Results From the School Health Policies and Programs Study 2006

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ABSTRACT

BACKGROUND: US schools employ an estimated 6.7 million workers and are thus an ideal setting for employee wellness programs. This article describes the characteristics of school employee wellness programs in the United States, including state-, district-, and school-level policies and programs.

METHODS: The Centers for Disease Control and Prevention conducts the School Health Policies and Programs Study every 6 years. In 2006, computer-assisted telephone interviews or self-administered mail questionnaires were completed by state education agency personnel in 49 states plus the District of Columbia and among a nationally representative sample of school districts ($n = 445$). Computer-assisted personal interviews were conducted with personnel in a nationally representative sample of elementary, middle, and high schools ($n = 873$).

RESULTS: During the 2 years preceding the study, 67.3% of states provided assistance to districts or schools on how to develop or implement faculty and staff health promotion activities or services. Although nearly all schools offered at least 1 health promotion service or activity, few schools offered coordinated activities and services within a comprehensive employee wellness program. During the 12 months preceding the study, none of the health screenings were offered by more than one third of schools; only a few of the health promotion activities and services were offered by more than one third of schools; about one third of schools offered physical activity programs, employee assistance programs, and subsidies or discounts for off-site health promotion activities; and only 1 in 10 schools provided health-risk appraisals for faculty and staff.

CONCLUSIONS: More schools should implement comprehensive employee wellness programs to improve faculty and staff health behaviors and health status.

Keywords: employee wellness; health promotion; schools; school policy; surveys.

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Approximately two thirds of deaths among adults aged 25 years and older in the United States can be attributed to preventable risk factors, including tobacco use, poor eating habits, inadequate physical activity, and alcohol and other drug use.¹ US schools employ an estimated 6.7 million workers, or nearly 4.5% of the nation's workforce, and are ideal settings for promoting adult health through employee wellness programs.² Moreover, many schools already have key facilities (eg, gymnasiums, swimming pools, fitness centers, and athletic fields) and staff (eg, health and mental health professionals, health and physical education teachers, classroom teachers, and nutrition services staff) to support employee wellness programs.³

School employees are susceptible to the same health risks and concerns that affect students, and many of these health risks are the same as those experienced by adults in other worksites. For example, many school employees lack adequate physical activity and proper nutrition; are asthmatic, diabetic, or obese; distracted by family or financial problems; and experience high levels of stress.⁴ Teachers, in particular, identify stress as a primary concern.⁵ Maintenance workers, bus drivers, and clerical staff may have ergonomic injuries from repetitive activities and lifting, and teachers and other staff may have chronic respiratory infections and voice disorders because of poor indoor air quality.⁵

Studies of employee wellness programs in private business and industry have shown positive outcomes on employee health and well-being,^{6,7} and it is likely that the findings from these studies are generalizable to schools.^{4,8} School employee wellness programs have been associated with reduced employee absenteeism,⁹ improved teacher morale,¹⁰ increased physical activity, weight loss, lowered blood pressure, and higher levels of general well being.¹¹ A well-developed school employee wellness program provides staff members with an integrated approach to improving their health, creates an environment that reduces exposure to threats to their health, and incorporates health promotion into the culture of the worksite.

School employee wellness programs also have been shown to be cost effective. After implementing a program, school districts have experienced considerable cost savings due to the need for fewer substitutes for absent teachers¹² and fewer health insurance claims.¹³ A study⁹ conducted in the Washoe County School District in Nevada found a cost savings of \$15.60 for every dollar spent on a school employee wellness program as a result of reduced staff absenteeism.

The launching of the Seaside Health Education Conference (later called the Seaside Health Promotion Conference) in 1977 was a turning point in the recognition of the important role that schools can

play in promoting faculty and staff health. The Oregon Department of Education brought together teams of school administrators, counselors, health and physical education teachers, school nurses, and school board members from throughout the state to build awareness of the importance of school health education, including the promotion of health among teachers and other staff.^{3,14} By 1990, more than 25 states had held a Seaside-style conference,¹⁵ and nearly 60% of these conferences had a school employee wellness program component.¹⁶ In recent years, several states have discontinued statewide school health promotion conferences because of lack of resources. Other states have incorporated school employee wellness program topics and activities into school health program institutes.

Healthy People 2010 national health Objective 7-5 to increase the proportion of worksites that offer comprehensive employee health promotion programs to 75% and objective 7-6 to increase the proportion of employees who participate in employer-sponsored health promotion activities to 75%¹⁷ articulate federal-level support for employee wellness programs and activities. Other *Healthy People 2010* objectives address specific employee wellness program activities, such as increasing the number of worksites that offer nutrition or weight-management counseling (Objective 19-16) and physical activity and fitness programs (Objective 22-13), reducing work-related injuries (Objective 20-2), or providing programs to prevent or reduce employee stress (Objective 20-9).¹⁷

Faculty and staff health promotion is 1 of 8 key components of a school health program.¹⁸ Efforts to improve the quality of life, health, and productivity of school employees are thus both separate from and integrated with efforts to improve the education and health outcomes of students.¹⁹ *School Employee Wellness: A Guide for Protecting the Assets of Our Nation's Schools*⁴ describes the components of a comprehensive school employee wellness program; a systematic approach to implementing a school employee wellness program, including health education and health-promoting activities; screenings to identify chronic disease risk factors; organizational policies that support employee wellness programs; and employee assistance programs (EAPs). The guide recommends the integration of these programs into the school or district structure, the inclusion of individual follow-up interventions to support behavior change for health risks that are identified by health assessments, and the provision of education and resources to inform health care decision making. Programs also should include a mechanism for evaluating effectiveness and efficiency.

School worksite health promotion is receiving increasing attention. For example, an Association of School Business Officials International (ASBO) survey

found that 53% of the ASBO members agreed that district employee wellness programs might help control rising health care costs, which were averaging nearly 10% of total school district expenditures and hindering the ability of districts to provide academic services to students.²⁰ Furthermore, the Alliance for a Healthier Generation, an initiative of the American Heart Association and the William J. Clinton Foundation to reduce childhood obesity, has identified increasing resources for teachers and staff to become healthy role models as 1 of 3 key school program objectives.²¹ In addition, the Mariner Project, an approach to organizing school health programs, uses support for a school employee wellness coordinator and employee wellness program recruitment as 2 of 11 elements for evaluating the effectiveness of program implementation.²² School health coordinators can use the introduction of employee wellness activities as a strategy for obtaining employee support for the implementation of other components of a school health program.²³ Finally, after completing the School Health Index, a self-assessment tool for school health programs, schools often decide to start their school health program activities with a focus on faculty and staff health promotion because they find that this component is the least developed.⁴

In 2000, the School Health Policies and Programs Study (SHPPS) provided the first descriptive data on the prevalence of school faculty and staff health promotion policies and programs nationwide.²⁴ This article describes findings from SHPPS 2006 about state-, district-, and school-level health insurance policies and programs, required health examinations and screenings, other health screenings, EAPs, health-risk appraisals, planning, and coordination. At the district and school levels, this article also describes health promotion activities and services and off-site health promotion activities. In addition, the article describes changes in key faculty and staff health promotion policies and programs from 2000 to 2006. While this article is primarily descriptive in nature, the Centers for Disease Control and Prevention (CDC) intends to conduct more detailed analyses and encourages others to conduct their own analyses using the questionnaires and public-use data sets available at www.cdc.gov/shpps.

METHODS

Detailed information about SHPPS 2006 methods is provided in "Methods: School Health Policies and Programs Study 2006" elsewhere in this issue of the *Journal of School Health*. The following section provides a brief overview of SHPPS 2006 methods specific to the faculty and staff health promotion component of the study.

SHPPS 2006 assessed faculty and staff health promotion at the state, district, and school levels. State-level data were collected from education agencies in 49 states plus the District of Columbia. District-level data were collected from a nationally representative sample of public school districts. School-level data were collected from a nationally representative sample of public and private elementary schools, middle schools, and high schools.

Questionnaires

The state- and district-level faculty and staff health promotion questionnaires assessed health insurance practices, required physical examinations and screenings, specific health promotion activities and services, EAPs, health-risk appraisals, and planning and coordination of health promotion activities and services for faculty and staff. The district-level questionnaire also assessed off-site health promotion activities.

The school-level questionnaire assessed health insurance practices, required examinations and screenings, specific health promotion activities and services, EAPs, health-risk appraisals, off-site health promotion activities, and planning and coordination of health promotion activities and services for faculty and staff.

Data Collection and Respondents

State- and district-level data were collected by computer-assisted telephone interviews or self-administered mail questionnaires. Designated respondents for each of 7 school health program components (ie, health education, physical education and activity, health services, mental health and social services, nutrition services, healthy and safe school environment, and faculty and staff health promotion) completed the interviews or questionnaires. At the state level, the state-level contact designated a single respondent for each component. At the district level, the district-level contact could designate a different respondent for each questionnaire or questionnaire module. A single district-level respondent was designated to respond to the faculty and staff health promotion questionnaire because it was not divided into modules. All designated respondents had primary responsibility for, or were the most knowledgeable about, the policies and programs addressed in the particular questionnaire or module.

After a state- or district-level contact identified respondents, each respondent was sent a letter of invitation and packet of study-related materials. Each packet contained a paper copy of the questionnaire(s) so that respondents could prepare for the interview and provided a toll-free number and access code that

respondents could use to initiate the interview. Respondents were told that the questionnaire(s) could be used in preparation for their telephone interview or completed and returned if self-administration was preferred. One week after packets were mailed, trained interviewers from a call center placed calls to them to schedule and conduct telephone interviews. In April 2006, telephone interviewing ceased and most of the remaining state- and district-level data collection occurred via a mail survey. All remaining respondents were mailed paper questionnaires and return envelopes; however, interviewers remained available for any respondents who chose to contact the call center.

At the end of the data collection period (October 2006), 74% of state-level faculty and staff health promotion questionnaires had been completed via telephone interview and 26% as paper questionnaires. The completed district-level questionnaires were completed via telephone interviews 45% of the time.

School-level data were collected by computer-assisted personal interviews. During recruitment, the principal or another school-level contact designated a faculty or staff respondent for each questionnaire or module, who had primary responsibility for or the most knowledge about the particular component. For the faculty and staff health promotion interview, the most common respondents were school nurses, principals, and assistant principals or other school administrators.

Response Rates

Ninety-eight percent ($n = 50$) of the state education agencies completed the state-level faculty and staff health promotion questionnaire. At the district level, 715 districts were eligible for the faculty and staff health promotion interview and 64% ($n = 461$) of these districts completed the interview. At the school level, 1282 schools were eligible for the faculty and staff health promotion interview, and 66% ($n = 849$) of these schools completed the interview.

Data Analysis. Data from state-level questionnaires are based on a census and are not weighted. District- and school-level data are based on representative samples and are weighted to produce national estimates.

Because of missing data, the denominators for each estimate vary slightly. Figures 15 and 16 in Appendix 1 of this issue of the *Journal of School Health* show the estimated standard error associated with an observed estimate from the district- and school-level faculty and staff health promotion questionnaires.

To analyze changes between SHPPS 2000 and SHPPS 2006, many variables from SHPPS 2000 were recalculated so that the denominators used for both years of data were defined identically. In most cases,

this denominator included all states, districts, or schools rather than a subset of states, districts, or schools. As a result of this recalculation, percentages previously reported for SHPPS 2000²⁴ might differ from those reported in this article. Only estimates from 2000 and 2006 based on this same denominator should be compared.

Because state-level data are based on a census, statistical tests for differences between 2000 and 2006 are not appropriate. Therefore, this article highlights changes over time meeting at least 1 of 2 criteria: (1) the difference was greater than 10 percentage points or (2) the 2006 estimate increased by at least a factor of 2 or decreased by at least half as compared with the 2000 estimate. At the district and school levels, *t* tests were used to compare SHPPS 2000 and SHPPS 2006 prevalence estimates. However, to account for multiple comparisons, this article only highlights changes over time meeting at least 2 of 3 criteria: (1) a *p* value less than .01 from the *t* tests, (2) a difference greater than 10 percentage points, or (3) the 2006 estimate increased by at least a factor of 2 or decreased by at least half as compared with the 2000 estimate. Note that not all variables meeting these criteria are presented in this article.

RESULTS

Faculty and Staff Health Promotion at the State and District Levels

Health Insurance. About half (54.0%) of all states offered health insurance to faculty and staff (ie, the state paid for some or all of the cost of the insurance or made the insurance available to faculty and staff at their own expense). Across all states, the health insurance covered all or part of preventive health care (eg, physicals) in 53.1% of states, mental health care in 49.0% of states, immunizations in 45.8% of states, alcohol- or other drug-use treatment in 44.9% of states, dental care in 34.7% of states, and vision care in 34.0% of states. Only 6.0% of states had adopted a policy stating that districts will offer health insurance to faculty and staff, and only 2.0% of states had adopted a policy stating that the health insurance will cover all or part of preventive health care or dental care. No states had adopted a policy stating that the district's health insurance will cover all or part of alcohol- or other drug-use treatment, immunizations, mental health care, or vision care.

Among the 46.0% of districts that indicated their state did not offer health insurance to faculty and staff, 98.4% offered health insurance to faculty and staff. This health insurance covered all or part of preventive health care in 94.2% of districts, mental health care in 91.5% of districts, alcohol-use or other

drug-use treatment in 86.2% of districts, immunizations in 81.2% of districts, dental care in 67.3% of districts, and vision care in 65.5% of districts.

Required Health Examinations and Screenings.

One fifth of states and more than one fourth of districts required all faculty and staff to receive a physical health examination and tuberculosis (TB) test prior to employment (Table 1). However, few states and districts required all faculty and staff to receive illegal drug-use screening prior to employment. In contrast, states and districts were more likely to require illegal drug-use screening prior to employment based on the person's position at the school. For example, requirements for teachers might differ from those for bus drivers.

Few states and districts required all school faculty and staff to receive periodic physical health examinations, illegal drug-use screenings, or routine TB tests while employed (Table 1). However, states and districts were more likely to require faculty and staff based on their position at the school to receive these examinations and screenings while employed.

Among the 36.7% of states and 56.3% of districts that required TB testing for any faculty and staff prior to or during employment, 42.9% of states and 53.4% of districts required a purified protein derivative (PPD) skin test be done by the Mantoux method, 14.3% of states and 18.4% of districts required a skin test but did not specify the method, no states and fewer than 1.0% of districts required a chest x-ray, and 42.9% of states and 28.0% of districts did not specify the method to be used when initially testing faculty and staff for TB.

Other Health Screenings.

Few states had adopted a policy stating that districts or schools will provide funding for or offer screening to faculty and staff for blood pressure, breast cancer, colorectal cancer, diabetes, height and weight or body mass, oral health, serum cholesterol, or skin cancer (Table 2). During the 12 months preceding the study, more than one

tenth of districts provided funding for or offered faculty and staff blood pressure, diabetes, height and weight or body mass, and serum cholesterol screening.

Health Promotion Activities and Services.

Few states had adopted a policy stating that districts or schools will provide funding for or offer health promotion activities (defined as classes, workshops, distribution of materials, or individual- or group-counseling sessions) for faculty or staff (Table 3). In contrast, during the 12 months preceding the study, more than half of districts provided funding for health promotion activities or offered health promotion activities related to cardiopulmonary resuscitation (CPR) education (73.8%), emergency preparedness (ie, how to be ready for a natural disaster or other crisis situation) (67.6%), and worksite safety education (56.2%).

Fewer than one fifth of states had adopted a policy stating that districts or schools will provide funding for or offer health promotion services, including identification of or referrals for physical, sexual, or emotional abuse; immunizations, not including those covered through health insurance (eg, flu vaccines); referrals for child care or elder care; and referrals for oral health problems (Table 3). Similarly, during the 12 months preceding the study, fewer than one fifth of districts provided funding for or offered identification of or referrals for physical, sexual, or emotional abuse; referrals for child care or elder care; and referrals for oral health problems. However, during the 12 months preceding the study, 53.8% of districts provided funding for immunizations or offered immunizations.

Only 6.0% of states had adopted a policy stating that districts or schools will provide funding for or offer any kind of physical activity programs for faculty and staff, such as aerobics classes, basketball leagues, or walking or jogging clubs. During the 12 months preceding the study, 36.3% of districts

Table 1. Percentage of All States, Districts, and Schools That Required Physical Health Examinations and Screenings for School Faculty and Staff, SHPPS 2006

Examination or Screening	% of All States		% of All Districts		% of All Schools	
	For All Faculty and Staff	Based on Person's Position	For All Faculty and Staff	Based on Person's Position	For All Faculty and Staff	Based on Person's Position
Prior to employment						
Physical health examination	20.0	12.0	28.4	31.0	27.6	11.4
Illegal drug-use screening	4.1	14.3	8.6	44.8	16.2	14.8
TB testing	26.0	6.0	42.9	11.9	47.9	6.3
While employed						
Physical health examination	4.0	10.0	3.2	33.7	4.6	9.4
Illegal drug-use screening	4.2	12.5	2.3	56.7	3.0	17.1
TB testing	8.2	4.1	8.5	9.8	16.3	5.9

TB, tuberculosis.

Table 2. Percentage of All States That Required Districts or Schools to Provide Funding for or Offer Screenings, Percentage of All Districts That Provided Funding for or Offered Screenings,* and Percentage of All Schools That Offered Screenings for Faculty and Staff,* SHPPS 2006

Screening	% of All States That Required Screenings	% of All Districts That Provided Funding for or Offered Screenings	% of All Schools That Offered Screenings
Blood pressure	4.0	39.0	32.8
Breast cancer	2.0	7.0	3.0
Colorectal cancer	0	5.0	1.7
Diabetes	0	14.6	9.6
Height and weight or body mass	2.0	23.3	13.2
Oral health	2.0	6.3	4.2
Serum cholesterol	2.0	18.8	13.3
Skin cancer	2.0	2.8	1.7

*During the 12 months preceding the study.

provided funding for or offered physical activity programs for faculty and staff. Few (6.3%) states had adopted a policy stating that indoor or outdoor school facilities or equipment (eg, gyms, cafeterias, swimming pools, weight-lifting equipment, or cardiovascular exercise equipment) will be made available to

faculty and staff as a benefit of their employment (not just because the facilities or equipment were available to all residents of a community). However, 42.9% of districts had adopted such a policy.

Employee Assistance Programs. EAPs were defined as services designed to assist employees experiencing personal or social problems that can impact work performance, physical health, or overall well-being. About one fourth (24.4%) of states had adopted a policy stating that districts or schools will provide funding for or offer an EAP for faculty and staff. During the 12 months preceding the study, 21.6% of districts provided funding for or offered an EAP for faculty and staff.

Health-Risk Appraisals. Health-risk appraisals were defined as questionnaires used to assess self-reported risk factors, such as smoking and physical inactivity. A health-risk appraisal also may be called a health-risk survey. Only 2.0% of states had adopted a policy stating that districts or schools will provide funding for or offer health-risk appraisals for faculty and staff. During the 12 months preceding the study, 12.3% of districts provided funding for or offered health-risk appraisals for faculty and staff.

Off-Site Health Promotion Activities. One way for districts to provide funding for health promotion activities is to provide subsidies or discounts for off-site health promotion activities. In 22.4% of districts

Table 3. Percentage of All States That Required Districts or Schools to Provide Funding for or Offer Health Promotion Activities and Services, Percentage of All Districts That Provided Funding for or Offered Health Promotion Activities and Services,* and Percentage of All Schools That Offered Health Promotion Activities and Services for Faculty and Staff,* SHPPS 2006

	% of All States That Required Activities and Services	% of All Districts That Provided Funding for or Offered Activities and Services	% of All Schools That Offered Activities and Services
Health promotion activity			
Asthma management education	10.2	19.2	19.8
CPR or CPR education	20.0	73.8	70.5
Conflict resolution education	10.0	29.3	33.7
Counseling for emotional disorders (eg, anxiety and depression)	10.2	14.5	20.6
Crisis intervention for personal problems	4.0	17.3	27.0
Diabetes management education	6.3	20.9	19.2
Emergency preparedness	24.5	67.6	76.8
Nutrition education	8.0	32.1	17.1
Physical activity and fitness counseling	6.0	24.8	15.6
Pre- or postnatal education	0.0	4.0	1.5
Stress management education	4.0	21.8	22.4
Tobacco-use cessation	16.3	17.6	12.6
Weight management	2.0	27.8	17.0
Worksite safety education	17.0	56.2	51.4
Health promotion service			
Identification of or referrals for physical, sexual, or emotional abuse	10.0	14.3	19.5
Immunizations, not including those offered through health insurance (eg, flu vaccines)	12.0	53.8	53.4
Referrals for child care or elder care	2.1	8.8	12.1
Referrals for oral health problems	2.0	5.1	5.6

CPR, cardiopulmonary resuscitation.

*During the 12 months preceding the study.

nationwide, faculty and staff received subsidies or discounts for off-site health promotion activities, such as health club memberships, weight loss programs, or tobacco-use cessation programs.

Planning. During the 2 years preceding the study, 67.3% of states provided assistance, including model policies, model programs, or written materials, to districts or schools on how to develop or implement faculty and staff health promotion activities or services.

Among the 93.7% of districts that provided funding for or offered any health promotion service or activity, when planning services for faculty and staff, 79.8% of districts considered improving job performance, 77.5% considered improving faculty and staff morale, 74.5% considered creating a positive image in the community, 72.0% considered creating an environment in which faculty and staff serve as "healthy" role models for students, 68.7% considered reducing the number of faculty and staff injuries, 67.8% considered addressing the health needs of faculty and staff, 67.2% considered attracting and retaining good faculty and staff, 61.5% considered reducing the number of sick days used, and 54.5% considered reducing the use or cost of health insurance benefits. During the 2 years preceding the study, 26.6% of districts assessed faculty and staff satisfaction with health promotion services and activities.

Among the 93.7% of districts that provided funding for or offered any health promotion service or activity, during the 12 months preceding the study 20.7% provided public recognition, 18.4% provided certificates or awards, 14.2% provided gifts, 8.3% provided monetary incentives, 6.2% provided paid time off, and 4.9% provided health insurance premium discounts to encourage participation in health promotion activities.

Coordination. One fourth (24.0%) of states had someone at the state level to oversee or coordinate health promotion activities or services for faculty and staff throughout the state. Among the 93.7% of districts that provided funding for or offered any health promotion service or activity, 44.4% had someone to oversee or coordinate health promotion activities or services for faculty and staff throughout the district. Nationwide, 18.0% of districts had adopted a policy stating that each school will have someone to oversee or coordinate health promotion activities or services for their faculty and staff.

During the 12 months preceding the study, among the 44.4% of districts that had someone to oversee or coordinate health promotion activities or services for faculty and staff, the coordinator worked on those activities or services with district-level nutrition or food service staff in 68.6% of districts, with health services staff in 65.6% of districts, with health education staff in 62.2% of districts, with

physical education staff in 60.2% of districts, and with mental health or social services staff in 31.6% of districts.

During the 12 months preceding the study, organizations and agencies helped provide health promotion activities for faculty and staff. Specifically, among the 93.7% of districts that provided funding for or offered any health promotion service or activity, a local health department helped provide activities in 44.0% of districts, a health organization (eg, the American Heart Association or the American Cancer Society) in 39.8% of districts, a local hospital in 30.5% of districts, a local health or fitness club in 21.3% of districts, a local business in 15.5% of districts, a mental health or social services agency in 14.4% of districts, a managed care organization in 8.9% of districts, and a university or medical school in 4.1% of districts.

Changes Between 2000 and 2006 at the State and District Levels. Between 2000 and 2006, the percentage of both states and districts requiring TB testing for school faculty and staff decreased. Specifically, the percentage of states with a TB-testing requirement for any faculty and staff prior to employment decreased from 76.6% to 32.0%, and the percentage of districts with a similar requirement decreased from 67.0% to 55.1%. In addition, the percentage of states with a routine TB-testing requirement for any faculty and staff while employed decreased from 46.8% to 14.3%, and the percentage of districts with a similar requirement decreased from 38.2% to 19.9%.

Similarly, the percentage of states requiring a physical health examination for any faculty and staff prior to employment decreased from 47.9% to 34.0%, and the percentage of states requiring a physical health examination for any faculty and staff while employed decreased from 32.7% to 14.0%.

Between 2000 and 2006, the percentage of states that had adopted a policy stating that districts or schools will provide funding for or offer to faculty and staff tobacco-use cessation activities increased from 2.0% to 16.3%, and the percentage of states that had adopted a policy stating that districts or schools will provide counseling for emotional disorders increased from 4.0% to 10.2%. Similarly, the percentage of states that had adopted a policy stating that districts or schools will provide funding for or offer EAPs for faculty and staff increased from 8.5% to 24.4%. In addition, the percentage of states that had adopted a policy stating that indoor or outdoor school facilities or equipment that could be used for physical activity be made available for faculty and staff increased from 2.0% to 6.3%.

Between 2000 and 2006, the percentage of districts providing funding for or offering faculty and staff nutrition education increased from 11.0% to 32.1% and the percentage providing funding for or

offering weight management increased from 12.7% to 27.8%. In addition, the percentage of districts providing funding for or offering physical activity programs increased from 24.2% to 36.3%.

Faculty and Staff Health Promotion at the School Level

Health Insurance. Questions on health insurance were posed only to private school respondents because public school faculty and staff receive health insurance from the state or district. Among private schools, 92.0% paid for some or all of the cost of insurance or made it available to faculty and staff at their own expense. The health insurance covered all or part of preventive health care in 87.2% of all private schools, mental health care in 84.3% of all private schools, immunizations in 73.6% of all private schools, alcohol-use or other drug-use treatment in 68.1% of all private schools, dental care in 58.8% of all private schools, and vision care in 49.7% of all private schools.

Required Health Examinations and Screenings. Nationwide, 27.6% of schools required a physical health examination, 16.2% required illegal drug-use screening, and 47.9% required TB testing for all faculty and staff prior to employment (Table 1). Fewer schools required these examinations or screenings prior to employment based on the person's position at the school. Similarly, few schools required physical health examinations, illegal drug-use screening, and TB testing periodically for all faculty and staff or based on a person's position at the school while employed.

Among the 58.2% of schools that required TB testing for any faculty and staff prior to or during employment, 83.4% required a PPD skin test be done by the Mantoux method, 6.8% required a skin test but did not specify the method, no schools required a chest x-ray as the type of test, and 9.8% did not specify the method to be used when initially testing faculty and staff for TB.

Other Health Screenings. During the 12 months preceding the study, the most common types of screening offered by schools to faculty and staff were blood pressure (32.8%), serum cholesterol (13.3%), and height and weight or body mass (13.2%) (Table 2).

Health Promotion Activities and Services. During the 12 months preceding the study, more than half of schools offered CPR education, emergency preparedness, and worksite safety education for faculty and staff (Table 3). Similarly, 53.4% of schools offered immunizations for faculty and staff, not including those offered through health insurance. Fewer schools offered identification of or referrals for physical, sexual, or emotional abuse; referrals for child care or elder care; and referrals for oral health problems for faculty and staff.

During the 12 months preceding the study, physical activity programs, such as aerobics classes, bas-

ketball leagues, or walking or jogging clubs, were offered to faculty and staff in 38.3% of schools. In 68.6% of all schools, indoor or outdoor school facilities or equipment that could be used for physical activity were made available for the school's faculty and staff to use.

Employee Assistance Programs. During the 12 months preceding the study, an EAP was offered to faculty and staff in 31.7% of schools.

Health-Risk Appraisals. During the 12 months preceding the study, 9.3% of schools provided health-risk appraisals for faculty and staff.

Off-Site Health Promotion Activities. Faculty and staff in 33.8% of schools received subsidies or discounts for off-site health promotion activities, such as health club memberships, weight loss programs, or tobacco-use cessation programs.

Planning. Among the 96.2% of schools that offered any health promotion service or activity during the 12 months preceding the study, when planning health promotion activities or services for faculty and staff, 70.5% of schools considered improving job performance, 70.3% considered creating a positive image in the community, 66.6% considered attracting and retaining good faculty and staff, 66.3% considered creating an environment in which faculty and staff serve as "healthy" role models for students, 65.8% considered improving faculty and staff morale, 55.4% considered addressing the health needs of faculty and staff, 48.2% considered reducing the number of faculty and staff injuries, 38.7% considered reducing the number of sick days used, and 34.4% considered reducing the use or cost of health insurance benefits. During the 2 years preceding the study, 24.2% of schools assessed faculty and staff satisfaction with health promotion activities or services.

Among the 96.2% of schools that offered any health promotion service or activity during the 12 months preceding the study, some schools provided incentives to faculty and staff for participation in health promotion activities, including public recognition (21.4%), certificates or awards (16.1%), gifts (11.4%), monetary incentives (8.5%), health insurance premium discounts (5.8%), and paid time off (4.5%).

Among the 96.2% of schools that offered any health promotion service or activity during the 12 months preceding the study, more than one third of schools promoted health programs for faculty and staff by posting fliers or bulletins at the schools (48.6%), making announcements at staff meetings (45.1%), and sending e-mails to faculty and staff (41.9%). Other methods used by schools to promote health programs for faculty and staff included placing notices or articles in school newsletters or newspapers (26.7%), holding competitions between groups

of faculty and staff (26.4%), posting notices on the school Web site (17.9%), mailing letters directly to faculty and staff (15.6%), offering special assemblies or presentations (14.9%), including notices with paychecks or sending them with pay stubs (14.5%), and giving release time for participation in health promotion activities (13.9%).

Coordination. Among the 96.2% of schools that offered any health promotion service or activity during the 12 months preceding the study, 35.1% of schools had someone to oversee or coordinate health promotion activities or services for the school's faculty and staff. During the 12 months preceding the study, among the 35.1% of schools that had someone to oversee or coordinate health promotion activities or services, the coordinator worked on health promotion activities with health services staff in 64.1% of schools, with physical education staff in 54.4%, with health education staff in 51.4%, with nutrition or food service staff in 41.5%, and with mental health or social services staff in 37.6%.

Among the 96.2% of schools that offered any health promotion service or activity during the 12 months preceding the study, activities or services were offered by the local school district in 42.3% of schools, a health organization in 33.4% of schools, a local health or fitness club in 32.6%, a local health department in 32.1%, a local hospital in 28.8%, a mental health or social services agency in 17.9%, a local business in 14.4%, a managed care organization in 11.0%, and a university or medical school in 4.4%.

Changes Between 2000 and 2006 at the School Level. Between 2000 and 2006, the percentage of schools that required TB testing for any faculty and staff prior to employment decreased from 71.0% to 56.0% and the percentage of schools that required periodic TB testing for any faculty and staff while employed decreased from 38.0% to 24.9%. In addition, the percentage of schools that required a physical health examination for any faculty and staff prior to employment decreased from 59.3% to 42.3%.

Some changes were noted in screening and health promotion activities between 2000 and 2006. During the 12 months preceding the study, the percentage of schools offering skin cancer screening decreased from 4.6% to 1.7% and the percentage of schools offering breast cancer screening decreased from 8.7% to 3.0%. In addition, the percentage of schools offering stress management education during the 12 months preceding the study decreased from 36.3% to 22.4% and the percentage offering pre- or postnatal education decreased from 5.2% to 1.5%.

Finally, the percentage of schools that used special assemblies or presentations to promote health programs decreased from 25.3% in 2000 to 14.9% in 2006, whereas the percentage of schools that held

competitions between groups of faculty and staff increased from 12.1% to 26.4%.

DISCUSSION

The Partnership for Prevention²⁵ has identified 6 characteristics of effective employee wellness programs: (1) health promotion activities that focus on skill development and lifestyle behavior change, (2) safe and supportive environments that promote health, (3) integration of the school employee wellness program within the school or school district, (4) worksite screening programs (eg, blood pressure or cholesterol screening), (5) educational resources that enable school employees to make decisions about health and health care, and (6) an evaluation and improvement plan.

School-site health promotion for staff has received less attention than other components of the school health model, despite the fact that school health coordinators often use faculty and staff health promotion as an entry point for introducing school health programs. Results from SHPPS 2006 reveal that, although at least 3 of 4 states have a state-level coordinator for other school health program components, including health education, physical education and activity, health services, mental health and social services, and nutrition services, only 1 in 4 states has someone at the state level to oversee or coordinate health promotion activities or services for faculty and staff. These results highlight the need for states and districts to provide greater support for planning and coordination of faculty and staff health promotion programs.

Most schools do not require health examinations or illegal drug-use screening prior to or during employment. Although TB testing is required by about half of schools prior to employment, it is required by few schools during employment. The percentage of schools with TB testing requirements decreased from 2000 to 2006. This change is consistent with CDC's 2000 recommendation that mandated TB-testing programs be discouraged unless the targeted group contains substantial proportions of persons at high risk.²⁶

Although nearly all schools offered at least 1 health promotion activity or service to faculty and staff, few schools appeared to offer coordinated activities and services within a comprehensive employee wellness program. During the 12 months preceding the study, none of the health screenings were offered by more than one third of schools; only a few of the health promotion activities and services were offered by more than one third of schools; about one third of schools offered physical activity programs, EAPs, and subsidies or discounts for off-site

health promotion activities, and only 1 in 10 schools provided health-risk appraisals for faculty and staff.

With one third of new US teachers leaving the profession during their first 3 years and almost half leaving during the first 5 years,²⁷ improving teacher retention could be an incentive for providing additional support for faculty and staff health promotion activities and services. Because teachers identify stress as a primary concern,⁵ stress may be a factor contributing to poor teacher retention. Unfortunately, no more than 1 in 10 states required districts or schools to provide funding for or offer to faculty and staff stress management education, crisis intervention for personal problems, or counseling for emotional disorders (eg, anxiety and depression). About 1 in 5 districts and schools provided funding for or offered such activities during the 12 months preceding the study. However, the percentage of schools offering stress management education to faculty and staff actually decreased from 36% in 2000²⁴ to 22% in 2006.

School-based employee wellness programs have the potential to improve wellness among the estimated 6.7 million faculty and staff employed by schools in this country² and can result in significant cost savings from reduced occupational injuries, sick leave, and health care costs.⁴ These programs also influence indirectly the health of the millions of students who attend school every day. Given the number of employees working in the education system throughout the United States and the health-related resources and personnel available in schools nationwide, more districts and schools should implement employee wellness programs to improve health behaviors and the health status of faculty and staff. Programs that are comprehensive in nature, are incorporated into a broader school health program, and include the key components outlined above will be most effective.

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