**Continuing Education Contact Hour Opportunity Pending

Self-insurance: A Solution for Faculty and Staff Health Promotion? Pilot Study Findings

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Abstract

Faculty and staff health promotion is a cost-saving component of coordinated school health, but little is known about the comprehensiveness of these programs. Self-insured school districts require employees to contribute directly to the district's health insurance pool. The purpose of this pilot study was to identify the prevalence of self-insurance within Texas school districts and compare districts' health promotion efforts to agency-insured counterparts. Using an electronic questionnaire, human resource personnel described the characteristics of their district's insurance status, health insurance coverage, health promotion program components, and considerations when planning health-promoting activities or services for school faculty and staff. Thirteen percent of respondents reported their school districts as self-insured. No significant differences between self-insured and agency-insured districts were discovered regarding health insurance coverage, district-offered health promotion, physical activity promotion, planning considerations, or utilization of community resources. Regardless of insurance type, findings indicated an overall lack in comprehensiveness of district-offered health promotion services. This study supports the need to further investigate this school health component so that district employees can financially and physically benefit from health promotion activities or services.

Introduction

Coordinated school health (CSH) is commonly associated with fulfilling health-related needs for students; however, health promotion for faculty and staff addresses the health needs, services, and outcomes of school employees so that they can better serve their students and schools. This component encompasses but is not limited to providing health screenings for employees; establishing programs that aim to improve employees' physical, mental, and behavioral health; and developing workplace policies that protect and promote employee wellness (Directors of Health Promotion and Education, 2007).

One of the numerous benefits of worksite health promotion programs is the demonstrated reduction of health care costs that results from healthier employees (Gould & Johnson, 2010; Marx, Wooley, & Northrop, 1998). Galemore (2000) justified support for health promotion programs in schools due to their direct cost benefits such as lower health insurance premiums and indirect benefits such as reduced absenteeism. Many systematic reviews have analyzed the cost-benefits of worksite health promotion, including a 2013 article that calculated that the return on investment among 20 examined studies "ranged from 1.6 to 3.9 in dollars saved versus spent on the wellness programs" (Kaspin, Gorman, & Miller, 2013, p. 17). Documented examples of cost-savings are less abundant when the school is specified as the worksite setting, but a health promotion program for a Nevada school district observed a similar cost-saving trend (Aldana, Merrill, Price, Hardy, & Hager, 2004). Additionally, a Florida school district reported health care savings of 14% over a three-year period as a result of implementing a comprehensive employee wellness program (Herbert, 2011). Allegrante advised caution when interpreting savings because the effects may not generalize to all populations but nonetheless labeled faculty and staff health promotion an essential part of CSH based on its indirect cost benefits (1998).

The Centers for Disease Control and Prevention (CDC)'s School Health Policies and Practices Study (SHPPS) is a national survey that summarizes school-based efforts to comprehensively assess health and wellness conditions within school districts, including services and programs for their employees. SHPPS findings indicated that 46% of schools do not receive health insurance coverage from the state; among the 54% remaining, 98.4% provide district-funded coverage to their employees. These districts are therefore responsible for funding their faculty and staff either through agency-insured or self-insured health care plans (Eaton, Marx, & Bowie, 2007).

As defined by the Employee Benefits Security Administration (EBSA), self-insurance is a health insurance arrangement funded by a trust or from general assets with no evidence of any health insurance contract. Trends indicate that self-insured companies with 200 or more employees pay statistically significantly lower annual premiums than their agency-insured counterparts (Brien & Panis, 2011). Due to

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the potential cost-saving benefits of worksite health promotion programs, they may contribute to a company's ability to self-fund its health insurance. In Texas, self-insurance is a permissible option for school districts to implement (Texas Department of Insurance, 2012); however, research is limited on how frequently districts claim this status.

The purpose of this pilot study was to survey human resource (HR) representatives of Texas school districts to gauge the prevalence of self-insured and agency-insured health care plans that school districts provide to faculty and staff. This study sought to identify any shared characteristics that self-insured school districts might have, speculating whether self-insurance indicates more comprehensive faculty and staff health promotion programs. Based on this information, this study sought to answer the following: 1) What percentage of Texas school districts are self-insured; and 2) Do self- and agency-insured school districts differ with regard to health promotion policies, services, and programs they offer to faculty and staff? Considering the limited scholarship on faculty and staff health promotion research, this study aimed to provide preliminary information on this CSH component and guide further inquiry in this topic.

Methods

Pilot Study

Due to the paltry amount of research on faculty and staff health promotion, especially regarding its connection to insurance, the current study was viewed as a pilot experiment. This approach allowed the authors to collect quantitative information on the topic and simultaneously consider ways to refine research techniques before committing to more comprehensive data collection. The pilot format was preferred for the foray into an otherwise under-researched field of school health literature and afforded many opportunities for constructive evaluation. Its findings intended to serve as a springboard for more extensive research opportunities in this topic, including methodological techniques.

Participants

Participants in this study comprised a convenience sample of HR coordinators employed at Texas school districts. These personnel were regarded as the experts on their districts' health insurance policies and were also likely to be aware of faculty and staff health promotion efforts within their respective school districts. To minimize amount of participation time required, email was used to communicate with participants instead of phone calls or mailed surveys; resultantly, only school districts that provided email addresses for their HR coordinators were invited to participate. Email addresses provided in Texas Education Directory (AskTED) were utilized to contact these potential respondents. Districts that did not provide an email address were excluded from the study invitation. All correspondence with participants occurred between April and May, 2013.

Instruments

Responses were gathered using an electronic questionnaire, which inquired about the following topics: the insurance status of the school district; the district-provided health promotion opportunities offered to faculty and staff; and the districts' degree of investment in these programs as avenues to reduced health care costs. This questionnaire was synthesized using selected questions from two CDC resources: School Health Policies and Practices Study (SHPPS) and School Health Index (SHI).

SHPPS is conducted nationally every six years to document state, district, and school policies that may impact CSH implementation (CDC, 2013b). The 2006 version of the SHPPS questionnaire was the most recent version available for public access at the time of this study's completion. Although no specific reliability scores for the selected SHPPS 2006 questions, the questions from its predecessor, SHPPS 2000, contained kappa scores ranging 49.3% to 67.3% (Brener, Kahn, & Smith, 2003). SHPPS 2006 was reviewed by national school health professionals and revised using cognitive interviews with school employees to strengthen its quality (Kyle et al., 2007). In the current study, slight modifications to SHPPS questions were made to clarify that participants were responding as representatives of their district, not school, as this distinction may not have been clear out of the original questions' context. Additionally, three questions were created as variants of SHPPS questions to inquire about insurance status within each school district.

SHI is designed for use among school administrators, teachers, students, and the community in a collaborative effort to improve health within specific schools (CDC, 2013a). As a tool for non-health professionals, SHI's reliability has not been assessed for research purposes (CDC, 2013a); however it has been used to strengthen the methodological quality of SHPPS (Brener, Pejavara, & McManus, 2011). Questions from this tool were selected because they provided additional insight about the school's support for faculty and staff health promotion, but they were reworded to inquire about supportive resources available at the district level.

Additional questions were added to the survey to record respondents' self-identified job titles, in case the HR coordinators served multiple roles. The complete instrument contained 21 items: 16 duplicated or derived from SHPPS, four duplicated from SHI, and one identifying respondents' job descriptions. Approximately five questions per page were displayed to increase ease of navigation. Study authors pre-tested the questionnaire for usability before distributing the link to potential respondents.

Procedure

Personnel data files containing the reported names of HR representatives for each school district were downloaded. Out of approximately 1,200 school districts in Texas, AskTED provided 430 HR representatives' email addresses. These personnel constituted the population's sample. The questionnaire was administered electronically using Qualtrics, an online survey tool.

Email addresses were only used to contact respondents, not to record their survey results, to ensure response anonymity. The initial email invitation was sent in April 2013, and between April and May, 2013, two follow-up reminder emails were sent to non-respondents. Participants read an informed consent statement and electronically agreed to participate in the study. The survey took approximately 10 minutes to complete. After submitting their responses, participants were provided a link to the CDC's SHI in case they were interested in further assessing the state of health promotion within their schools or school districts.

Data Analysis

Statistical Package for the Social Sciences (SPSS), Version 20, was used to analyze data and report all findings. Statistical t-tests were conducted to determine if the self-insured and agency-insured school districts displayed statistically significant differences concerning the comprehensiveness of faculty and staff health promotion programs offered, although the number of participants in each insurance group was not known prior to data collection.

Human Subjects Approval Statement

The Texas A&M University Institutional Review Board reviewed and approved all procedures prior to survey administration.

Results

Sample Characteristics

Approximately 30 of the email addresses were defunct or outdated, resulting in 398 potential respondents. Eighty-four participants responded to the questionnaire, producing a response rate of 21%. HR coordinators or other HR personnel represented 40.5% (n=34) of responses, whereas the remaining survey respondents identified as payroll or benefits directors (13.1%), business managers (9.5%), superintendents (8.3%), faculty or staff (4.8%), administrative assistants (3.6%), other (3.6%), or having more than one title (8.3%).

Self-Insured School Districts

According to survey results, 13.6% (n=11) of sampled personnel reported their school districts as self-insured, while 86.4% (n=70) identified as not self-insured, or agency-insured. Based on t-test analysis, no statistically significant differences in health promotion program components were discovered between these two groups.

Insurance Availability

Nearly all (98.8%) sampled school districts reported offering health insurance to faculty and staff. The most common types of health promotion insurance coverage were preventive health care such as physicals (92.9%), immunizations (81.0%), mental health care (73.8%), and alcohol or other drug use treatment (65.5%) (Table 1).

Table 1.

Health Insurance Status and Components

Characteristics	*Overall (n=83)**	
	n	*%*
Does your district offer health insurance to faculty and staff?		
Yes	82	98.8
No	1	1.2
Is your district's health insurance coverage self-insured?		
Yes	11	13.6
No	70	86.4
Types of insurance programs offered by district		
Preventive health care, such as physicals	78	92.9
Immunizations	68	81.0
Mental health care	62	73.8
Alcohol or other drug use treatment	55	65.5
Vision care	46	54.8
Dental care	36	42.9
No insurance programs offered	1	1.2

* Missing data from participants were left unaltered during analysis

District-Provided Health Promotion

When asked whether or not their district offers faculty and staff health promotion activities or services, only 9.6% of respondents indicated that health education and health promoting activities focused on skill development and behavior change were offered. Responses affirming the availability of health assessments, physical activity/fitness programs, and healthy eating/weight management programs were similarly low (Table 2).

District-Provided Physical Activity Promotion

Most respondents (70.1%) reported their school districts did not offer any physical activity programs for faculty and staff within the past 12 months. Few districts (29.9%) reported offering subsidies or discounts to faculty and staff for off-site health promotion activities. However, close to half of districts (42.1%) stated they adopted a policy regarding the availability of on-site school recreational facilities for faculty and staff to use. No statistically significant differences were discovered between self-insured and agency-insured districts that offered physical activity programs for faculty and staff.

Considerations

When asked what respondents considered important when planning health promotion activities or services, the most commonly reported concerns were improving faculty and staff morale (73.1%), improving job performance (72.7%), and creating a positive image in the community (71.6%). Noticeably less consideration was given to reducing the use or cost of health insurance benefits (46.3%) and creating an environment in which faculty and staff serve as "healthy" role models for students (47.8%). No significant difference in planning considerations existed among self-insured and agency-insured school districts (Table 3).

Community Resources

Overall, the school districts' reported use of community resources for health promotion efforts was low. The most commonly used resources for health promotion at the district level were professional health organizations such as the American Heart Association (29.4%) and local health or fitness clubs (28.4%). Self-insured school districts' reported use of resources did not differ significantly from agency-insured districts (Table 4).

District Resources

District-level resources included health professionals employed at the district level, such as health education staff, physical education staff, health services staff, and nutrition/food services staff, with whom participants could potentially consult to facilitate employee wellness programs. Of the four staff categories, survey respondents collaborated with health services staff most often (30.4%); inversely, 37.7% of respondents had not worked with this type of personnel, while 31.9% reported not having this professional employed at their district (Table 5).

Discussion

Because 13.9% of respondents reported their school districts were self-insured, this confirms the presence of self-insurance among Texas school districts. One question that remains to be answered is where these self-insured school districts exist. Self-insurance in the corporate setting is most common in larger companies with over 200 employees, typically in more urban areas (Brien & Panis, 2011), but in order to guarantee anonymity to survey participants, the current study's methods did not assess where the trends occurred among school districts.

When comparing the two insurance types, no statistically significant differences were found in the health promotion program components, considerations, or efforts of self-insured school districts and their agency-insured counterparts. Based on these findings, it appears self-insurance does not suggest more comprehensive health promotion programs or services available to faculty and staff, yet the marginal number of self-insured school districts may have discouraged ascertaining statistically significant findings. Overall, both district types fell short of offering comprehensive health promotion programs to district faculty and staff.

According to SHPPS reports, Texas legally requires preventive health care, immunizations, mental health care, and vision care to be covered by district insurance (CDC, 2006), which is supported by the results related to insurance components commonly reported in this study. The legislation

Table 2.

Health Promotion Program Components

	Offered		Inaccessible*		Not Offered		Total n
District health promotion and services	n	%	n	%	n	%	
Health education and health- promoting activities	7	9.6	10	13.7	56	76.7	73
Health assessments at least once a year	21	29.6	6	8.4	44	62.0	71
Physical activity/fitness programs	13	18.1	3	4.2	56	77.8	72
Healthy eating/weight management programs	4	5.6	2	2.8	66	91.7	72

* Inaccessible - services are available, but employees perceive them as difficult to utilize (ie. cost-prohibitive).

Table 3

Health Promotion Considerations

	Total		Self-Insured		Agency-Insured	
Consideration is given to…	n	%	n	%	n	%
Addressing health needs of faculty/staff						
Yes	34	50.7	3	33.3	31	53.4
No	33	49.3	6	66.7	27	46.6
Reducing use/cost of health insurance benefits						
Yes	31	46.3	5	55.6	26	44.8
No	36	53.7	4	44.4	32	55.2
Reducing cost of health insurance for faculty/staff						
Yes	40	60.6	6	66.7	34	59.6
No	26	39.4	3	33.3	23	40.4
Reducing number of sick days used						
Yes	36	53.7	4	44.4	32	55.2
No	31	46.3	5	55.6	26	44.8
Improving job performance						
Yes	48	72.7	4	44.4	44	77.2
No	18	27.3	5	55.6	26	44.8
Improving faculty and staff morale						
Yes	49	73.1	4	44.4	45	77.6
No	18	26.9	5	55.6	13	22.4
Creating a positive image in community						
Yes	48	71.6	3	33.3	45	77.6
No	19	28.4	6	66.7	13	22.4
Creating an environment in which faculty/ staff serve as "healthy" role models for students						
Yes	32	47.8	3	33.3	29	50.0
No	35	52.2	6	66.7	29	50.0

set forth by Texas law leads to an intriguing observation found: why did some districts not report offering these types of coverage? A potential explanation is that respondents may have misunderstood the meaning of "coverage" in the question, thinking these services would be fully covered by their school districts when in reality "coverage" may have included co-payments or out-of-pocket expenses. Adding confusion to the issue is Texas's Insurance Code statute, section 1575, which states that a district may include these components in a basic plan but does not suggest any required insurance components (Tex. Ins. Code § 1575.151).

Miscommunication or misinterpretation may also explain discrepancies in reports on school districts' health promotion policies. For example, according to state-level SHPPS 2006 findings, Texas law requires schools to make on-site recreational facilities available to faculty and staff (CDC, 2006). However, Texas law implies this requirement is optional (Tex. Educ. Code §11.165), and only 42.1% of the current study's sampled districts reported implementing a district-level policy of some kind. It is unclear based on the findings whether these district-level policies are meant to clarify the ambiguity in the state-level policy or if the districts not writing a policy realize this access is an option. Nevertheless, the current study suggests the availability of on-site recreational facilities is not clear to district personnel, who consequently may not transfer this information to faculty and staff.

Another observation in this study is that health considerations do not appear to translate into health actions. For example, 50.7% of districts claimed to consider addressing the health needs of faculty and staff, but the majority of respondents reported that health education, health assessments, physical activity programs, and nutrition education programs were not offered at the district level. Although it is possible that schools, not districts, have established policies and programs supporting health promotion efforts, many districts do not appear able or willing to commit to the actions necessary to implement such efforts.

The community resources that Texas school districts most frequently reported using were health organizations (29.4%) and local health or fitness clubs (28.4%). This study's sample of districts sought these collaborative efforts more often than their national counterparts; 2012 SHPPS results chronicled 22.7% and 21.6% of districts seeking these respective partnerships (Demissie, Brener, & Goekler, 2013). Interestingly, these percentages reflect a decreasing trend in collaboration with these agencies, as SHPPS data from 2006 indicated higher usage – 44.0% and 29.8%, respectively (Eaton et al., 2007). It is unclear why schools and districts appear to be collaborating less frequently with organizations and agencies, and based on these differences, districts on both national and statewide levels

Table 4
Community Resources Used by District for Health Promotion

	Total		Self-Insured		Agency-Insured	
District reported using/partnering with…	n	%	n	%	n	%
Local health department						
Yes	18	26.5	1	11.1	17	28.8
No	50	73.5	8	88.9	42	71.2
Local hospital						
Yes	18	26.9	1	11.1	17	29.3
No	49	73.1	8	88.9	41	70.7
Mental health/social services agency						
Yes	6	9.0	1	11.1	5	8.6
No	61	91.0	8	88.9	53	91.4
University or medical school						
Yes	5	7.6	1	11.1	4	7.0
No	61	92.4	8	88.9	53	93.0
Managed care organization						
Yes	8	12.3	1	11.1	7	12.5
No	57	87.7	8	88.9	49	87.5
Health organization (ie. American Heart Association)						
Yes	20	29.4	2	22.2	18	30.5
No	48	70.6	7	77.8	41	69.0
Local health/fitness club						
Yes	19	28.4	1	11.1	18	31.0
No	48	71.6	8	88.9	40	69.0
Local business						
Yes	9	13.4	0	0.0	9	15.5
No	58	86.6	9	100	49	84.5

Table 5
Collaboration with District-Level Personnel Within Past 12 Months

	Total		Self-Insured		Agency-Insured	
Personnel on staff	n	%	n	%	n	%
Health education						
Yes	14	20.3	0	0.0	14	23.3
No	29	42.0	5	55.6	24	40.0
N/A*	26	37.7	4	44.4	22	36.7
Physical education						
Yes	18	26.1	0	0.0	18	30.0
No	30	43.5	5	55.6	25	41.7
N/A	30	30.4	4	44.4	17	28.3
Health services						
Yes	21	30.4	0	0.0	21	35.5
No	22	37.7	5	55.6	21	35.5
N/A	26	31.9	4	44.4	18	35.5
Nutrition/food services						
Yes	20	29.9	0	0.0	20	34.5
No	20	40.3	5	55.6	22	37.9
N/A	27	29.9	4	44.4	16	27.6

*N/A: district did not have type of district-level personnel on staff

may be underutilizing the available health promotion resources within their communities.

Texas districts also have more potential to work with health professionals who may be available in their districts. While 30.4% of Texas school districts reported collaborating with health services staff for faculty and staff health promotion, corresponding findings from the national sample show 63.7% of sampled districts utilize their health services staff (Demissie et al., 2013). The school districts in this study's sample can maximize the scope of faculty and staff health promotion programs by interacting with the school system as well as the local community. For school districts that do not have these district-level professionals available, school nurses could potentially serve as key informants to their districts, providing an insider's view to assess the needs of health services staff and arrange appropriate services based on collaborative findings. Ryan (2008) specifically calls upon school nurses to assess, plan, implement and evaluate health promotion services for school employees, but embarking on these tasks may be difficult without administrative support (Romano, 2001).

Another deviation from national SHPPS findings is that 72.0% of nationally sampled districts claimed to consider the school an important environment that creates healthy role models for students (Eaton et al., 2007), yet only 47.8% of the current sample made this same claim. This finding raises concerns about the presence of healthy role models while students are attending school. A possible explanation for this finding relates to respondents' characteristics; because HR and Payroll personnel constituted the majority of the sample, employees in these positions may only have an indirect role working with students within the schools and more fully focus on benefiting the district financially. Nevertheless, faculty and staff health promotion programs not only have the potential to save the district money, but they can also cultivate a community of wellness among faculty, staff, and students alike. As part of the CSH model, faculty and staff health promotion programs are an opportunity for school employees to become role models to students (Ryan, 2008) and administrative decisions should account for the payoff of these approaches.

Despite their knowledge of health insurance benefits, district-level HR coordinators may not have been the most knowledgeable personnel on school-level health promotion initiatives, which may also explain the minimal amounts of faculty and staff health promotion reported. Some schools may be able to build more comprehensive health promotion efforts, even if they are the only schools in their districts to do so, due to more "grassroots" efforts among employees. Social support and school climate could influence the growth of health promotion programs independently of district efforts. While it is possible that schools are leading the way with their own programs, activities, and services, it remains concerning that these schools may not be benefitting from resources and support that districts can provide.

Limitations

Although this study is one of the first to illuminate concerns about faculty and staff health promotion, its design has several limitations regarding representativeness that prompt caution about generalization of findings and extensive thought about how to analyze this topic in future research. With approximately 400 potential participants to represent 1200 districts, the sampling pool was deemed large enough, yet the low response rate within this sample (21%) inhibits generalization to the larger population. If this study is to be replicated on a larger scale, methods to increase response rate must be considered, such as including telephone reminders, computer-assisted interviews, or incentives to participate.

The exclusive use of state-provided email addresses to recruit HR personnel limited the number of respondents available, as it remains possible that some school districts could not be reached via email. This sampling method was designed to provide minimum inconvenience to sample participants and it was considered acceptable for gaining preliminary information about an otherwise under-researched topic. Limiting communication to emails created a potential bias towards districts with resources for both an HR coordinator and web-based communication, but it can be inferred that if these districts had a greater number of resources initially, they may be more likely to afford health promotion activities and services. Nevertheless, future efforts should incorporate other research tactics to lessen the effects of nonresponse bias, nonrepresentativeness, and missing data. Keeping these improvements in mind, future studies can expand to other recruitment methods to elicit higher participation rates from a more diverse sample of school districts.

The small number of self-insured school districts may have limited producing statistically significant differences related to insurance type. Future research on this topic may benefit from purposively selecting self-insured and agency-insured districts, confirming insurance status with respondents before questionnaires are administered. This clarification will lead to a more diverse, representative sample and ensure more accurate responses from the personnel who specialize in monitoring their school districts' health insurance status. Demographic and population data will also be collected to see where self-insured school districts most commonly exist.

Finally, although the survey was sent to district HR coordinators, many non-HR personnel completed the survey, a lack of consistency that may have limited the validity of the questionnaire responses. This limitation was insightful, though, demonstrating how many voices contribute to health promotion opportunities. To chronicle this collaboration, interviews or focus groups designed to ascertain opinions from a smaller number of school stakeholders – including administrative personnel, faculty, staff, parents, and students – may capture more perspectives on health promotion opportunities than a widely disseminated survey to just one group of school district representatives. If interviews are not possible, creating opportunities for free-response feedback on questionnaires will allow participants to share in-depth thoughts about health promotion efforts and their individual roles in conducting or participating in them.

Conclusions

As part of the CSH approach, faculty and staff health promotion is recognized as a component of school health and wellness, but results of this study indicate a lack of comprehensive district-supported health promotion programs within Texas. It is unclear what role, if any, self-insurance plays in health promotion efforts, as both self-insured and agency-

insured school districts could benefit from improvement. Mixed-methods assessment can be used in future studies to explore the reasons for these apparent lacks in service.

Positioned as a pilot study, authors present caution with interpreting the results. The small number of self-insured school districts may have diminished the value of t-test analyses comparing the two groups, and a larger, more representative sample would have provided more generalizability. Although limited, the conclusions drawn from this study were threefold: 1) self-insured school districts exist in Texas school districts; 2) school districts do not appear to maximize the health promotion efforts available for their employees regardless of insurance type; and 3) more research, including qualitative or mixed-methods approaches, is merited.

Although evidence in this study is minimal, school districts can begin to collectively plan and implement health promotion efforts. The various job descriptions of respondents suggest that many types of district employees have an interest in faculty and staff health promotion programs. This study's results indicate opportunities to improve correspondence among district administrators, school employees, school nurses, and community personnel to create sustainable, cost-saving health promotion programs for faculty and staff. As members of a CSH team, these correspondents have the potential to 1) define health promotion more clearly to administrative personnel; 2) calculate the cost-saving effects of a comprehensive health promotion program; 3) encourage the use of community and district resources, including considering the appointment of district-level health promotion staff; and 4) state the importance of modeling healthy lifestyles to students. A thorough, collaborative CSH approach can improve both the school districts' health care costs and the wellness of employees within them.

References

Aldana, S. G., Merrill, R. M., Price, K., Hardy, M. S., & Hager, R. (2004). Financial impact of a comprehensive multisite workplace health promotion program. *Preventive Medicine*, 40, 131-137. http://dx.doi.org/10.1016/j.ypmed.2004.05.008

Allegrante, J. P. (1998). School-site health promotion for faculty and staff: A key component of the coordinated school health program. *Journal of School Health*, 68, 190-195. doi: 10.1111/j.1746-1561.1998.tb01299.x'

Brener, N. D., Kahn, L., & Smith, T. K. (2003). Reliability and validity of the School Health Policies and Programs Study 2000 questionnaires. *Journal of School Health*, 73, 29-37.

Brener, N. D., Pejavara, A., & McManus, T. (2011). Applying the School Health Index to a nationally representative sample of schools: Update for 2006. *Journal of School Health*, 81, 81-90.

Brien, M. J., & Panis, C. W. A. (2011). *Self-insured health benefit plans* [PDF document]. Deloitte, Advanced Analytical Consulting Group. Retrieved from http://www.dol.gov/ebsa/pdf/deloitte2011-1.pdf

Centers for Disease Control and Prevention. (2006). Texas: Faculty and staff health promotion [PDF document]. *School Health Policies and Programs Study 2006 State Report Cards.* Retrieved from http://www.cdc.gov/healthyyouth/shpps/2006/report-cards/texas/RC_Texas_FSHP_SHPPS2006.pdf

Centers for Disease Control and Prevention (2013a). *Adolescent and school health: School health index.* Retrieved from http://www.cdc.gov/healthyyouth/shi/index.htm

Centers for Disease Control and Prevention (2013b). Adolescent and school health: *School health policies and practices study (SHPPS)*. Retrieved from http://www.cdc.gov/healthyyouth/shpps/

Demissie, Z., Brener, N. D., & Goekler, S. F. (2013). Faculty and staff health promotion: Results from the School Health Policies and Practices Study 2012. In *Results from the School Health Policies and Practices Study 2012* [PDF document]. Centers for Disease Control and Prevention. Retrieved from http://www.cdc.gov/healthyyouth/shpps/2012/pdf/shpps-results_2012.pdf

Directors of Health Promotion and Education. (2007). *School employee wellness: A guide for protecting the assets of our nation's schools* [PDF document]. Retrieved from http://www.dhpe.org/members/group_content_view.asp?group=87568&id=124831

Eaton, D. K., Marx, E., & Bowie, S. E. (2007). Faculty and staff health promotion: Results from the School Health Policies and Programs Study 2006. *Journal of School Health*, 77, 557-566. doi: 10.1111/j.1746-1561.2007.00235.x

Galemore, C. A. (2000). Worksite wellness in the school setting. *Journal of School Nursing*, 16(2), 42-45.

Gould, R. J., & Johnson, R. K. (2010). *Healthy workforce 2010 and beyond: An essential health promotion sourcebook for both large and small employers* [PDF document]. Partnership for Prevention, US Chamber of Commerce. Retrieved from http://www.prevent.org/downloadStart.aspx?id=18

Herbert, M. (2011). Wellness program reduces employee healthcare costs. *District Administration, 47*. Retrieved from http://www.districtadministration.com/article/wellness-program-reduces-employee-healthcare-costs

Kaspin, L. C., Gorman, K. M., & Miller, R. M. (2013). Systematic review of employer-sponsored wellness strategies and their economic and health-related outcomes. *Population Health Management*, 16, 14-21. DOI: 10.1089/pop.2012.0006

Kyle, T. M., Brener, N. D., Kann, L., Ross, J. G., Roberts, A. M., Iachan, R.,… McManus, T. (2007). Methods: School Health Policies and Programs Study 2006. *Journal of School Health*, 77, 398-407. doi: 10.1111/j.1746-1561.2007.00227.x

Marx, E., Wooley, S. F., & Northrop, D. (Eds.). (1998). *Health is academic: A guide to coordinated school health programs.* New York, NY: Teachers College Press.

Romano, J. C. (2001). The complicated task of managing school health programs. *Journal of School Nursing,* 17(3), 126-130.

Ryan, K. M. (2008). Health promotion of faculty and staff: The school nurse's role. *Journal of School Nursing,* 24(4), 183-189.

Texas Department of Insurance. (2012). *Certified self insurance*. Retrieved from http://www.tdi.texas.gov/wc/si/

Texas Education Code. (1999). Title 2: Public education. § 11.165

Texas Insurance Code. (2003). Title 8: Health insurance and other health coverages. § 1575.151.

This article may provide one
Continuing Education Contact Hour Opportunity for CHES (Approval Pending)

Instructions and self-study questions may be found on page 48

From the Editor...

As we say goodbye to 2014, I continue to be impressed by the work of our fellow health educators. For example, in this issue James and colleagues share their research in promoting physical activity among African American women and remind health educators to include women's belief systems when planning programs. Payton and Price provide a review of selection of published literature and interview results of health educators and school nurses to determine to what extent high schools address racial/ethnic health disparities. The authors of both of these studies provide thoughtful considerations of the continued need for health educators to focus on reducing health disparities.

Enhancing our advocacy skills can also help us address health disparities. Please take time to read about the perceptions of your fellow Gammans related to advocacy in the article by Cox and colleagues. We also are pleased to share the work of student Gammans (Hackett, Renschler & Kramer) who received an ESG Project Grant to evaluate a workplace conflict resolution workshop. Gilbert and colleagues also focus on employee health by describing characteristics of self-insured school districts.

Throughout this issue are articles depicting health educators engaged in working to improve the health of their communities. Hopefully, these articles in this journal and those in other professional journals will inspire us all to continue our efforts to improve the health of all individuals.

Finally, I would like to thank a hard-working group of Gammans who have completed their term of service as an Editorial Associates: Joyce Balls-Berry,

Jagdish Khubchandan, Sabrina Matoff-Stepp, Catherine Rasberry and Rebecca Vidourek. Thank you for lending us your time and talents.