A Culture-Based Differentiated Instruction Model: Addressing School, Community, and Health Related Behaviors through Health Education

**Abstract**

Current health related issues, education, and their associated costs continue to be debated throughout the United States of America, with immigration concerns receiving significant attention as well. Understanding culture is crucial and a new approach is needed, focusing on these interrelated national priorities. The Culture-Based Differentiated Instruction Model (CBDIM) was developed as a preventative, comprehensive framework to address underlying issues related to school behavior (performance, retention, graduation rate, etc.), community (empowerment, autonomy, self-efficacy, quality of life, etc.) and health related behaviors. The CBDIM focuses on culture and is designed to utilize the community as a partner in the learning and dissemination process. The aim of this article is to introduce and briefly explain the model, provide a rationale for structure and design, and present future research areas for exploration.

**Introduction**

The Culture-Based Differentiated Instruction Model (CBDIM) will be illustrated through a health education lens at the high school level, but may be applied to other subject areas and grade levels (K-12, college, older adults, etc.). The model is a framework to guide curriculum and individual classroom instruction to enact positive social change out in the corresponding community. A community outreach component is utilized in the model as a means for student learning and to address the stated outcomes.

High school graduation rates have been increasing across the USA over the past decade, however a current analysis suggests much work remains. As of 2012, 81% of students who enter public school in 9th grade finish with a regular diploma in four years (Stetser & Stillwell, 2014). The remaining 19% of at-risk students provide one potential cultural group that needs to be addressed. A closer inspection reveals gaping disparities and a significant amount of students are being left behind. In 2012, the overall graduation rate for African American (69%), American Indian/Alaska Native (67%), and Hispanic (73%) students were all lower than White (86%) and Asian/Pacific Islander students (88%) (Stetser & Stillwell, 2014). Ethnicity represents an additional culture group to account for. While each state in America experiences different graduation rates, there is room for improvement and a focus on eliminating disparities is justified.

Earning potential over the course of a lifetime has been linked to completion of a high school degree program. In 2012, median income for young adults without a high school credential was $22,900 compared to $30,000 for those with a credential, $46,900 with a bachelor’s degree, and $59,600 with a master’s degree or higher (National Center for Education Statistics (NCES), 2014). Increasing student performance and retention are vital to improving graduation rate. Both income and education levels are strong determinants of health and have a major impact on quality of life for an individual (World Health Organization (WHO), 2015).

Running parallel to performance, retention, and graduation rates are health related conditions experienced throughout a lifetime. A significant amount of high school students engage in behaviors that increase risk of morbidity and mortality both in the short term (motor vehicle crashes, homicide, suicide, and other unintentional injuries) and long term (CDC, 2014). Increasing income and education levels has been linked to lower rates of many long-term ailments that are also leading causes of mortality (cardiovascular disease, cancer, etc.) in the USA. (CDC, 2012). With billions of dollars in health care related costs at stake, continued focus on education is warranted.

**Overview**

The CBDIM consists of three main phases along with three parallel assessments. The model centers around Culture-Based Differentiated Instruction (CBDI), with a focus on community outreach, and three sets of outcomes related to school, community, and health related behaviors. Differentiated instruction is a teaching approach where different learning pathways are created based on individual student needs and learning styles (Dixon, Yessel, McConnell, & Hardin, 2014). While differentiated instruction is prevalent in the literature, the CBDIM as a whole is absent. The remainder of this article will introduce the model and provide justification for inclusion of specific components. The model is a framework to create curriculum based on cultural needs, utilizes community outreach in the learning process, and addresses the stated outcomes.

 Phase one consists of three levels. Level one centers on CBDI and branches into level two (planning, instructing and assessing) while focusing on the central theme. Level three entails four encircling constructs and are accounted for during planning, instruction, and assessment. These include classroom management, behavioral management, intrinsic motivation, and attendance rate. These constructs entail pre, present, and post strategies as well. Above the model the curricula scope and sequence is designed so units can be completed both sequentially and independently.

Phase one is linked closely with phase two (community outreach) as a means for dissemination, learning strategies for all members involved and aims to partner the community in the educational process. Phase three highlights the target outcomes. Formative assessments are utilized throughout phase one, impact assessments correspond with the community outreach component in phase two, and summative evaluation is conducted during phase three to measure the stated outcomes. Process evaluation not cited in the model takes place in all three assessment phases.

***“Insert Figure 1 here”***

**Phase One**

**Level One**

**Culture-Based Differentiated Instruction**

Individual student needs and learning styles are the focus when differentiating instruction and this can be ascertained through a variety of formative assessment strategies. Trying to meet the needs of each individual learner is not a new concept. The Association for Supervision and Curriculum Development (1953) outlined challenges of teaching to a room full of low and high skilled learners and ways to provide individualized instruction. Others have expanded on this research and shortly after the term “differentiated instruction” took hold in pedagogy literature. Dr. Virgil Ward developed a differentiated instructional approach and expanded on this theory to identify and meet the needs of gifted learners as he felt they had the biggest impact toward society throughout their lives (Ward, 1967; Ward, 1986). Present day differentiated instruction specialist Carol Tomlinson has published hundreds of articles that further expand and substantiate the effectiveness of this approach (Tomlinson, 2013).

Differentiated Instruction assesses a number of areas that impact student learning. A plan is formalized according to the student’s profile and instruction is then carried out to best meet student needs. Culture is one area accounted for in this individualized student assessment. However, the CBDIM focuses on culture as a starting point and is emphasized throughout the other components of the module.

Culture is being defined as shared knowledge, behavior and affective understanding displayed by a group of people and not solely based on ethnicity or proximity in a specific community. The PEN-3 model originally designed by Airhihenbuwa (1989) to address HIV/AIDS in Africa utilized a cultural approach and has since evolved to address a wide range of cultures and specific health issues. The model focuses on three primary domains that each consist of three components. Cultural identity (person, extended family, neighborhood), relationships and expectations (perceptions, enablers, nurturers), and cultural empowerment (positive, existential, negative) are used during assessment, planning, and implementation phases to address specific health issues (Airhihenbuwa, 1995).

The PEN-3 model reinforces the importance of culture and is grounded in the CBDIM approach. In addition, the PEN-3 model can be used to gain a better understanding of specific cultural groups that may be represented in the classroom and corresponding community. By gearing the model in this fashion, planning for, instructing, and assessing multiple cultures along with community outreach leads to a vital learning process that drives other areas of the model.

**Level Two**

**Planning**

The CBDIM requires extensive planning that focuses on culture, utilizes a differentiated instructional approach, and accounts for classroom and behavior management, intrinsic motivation, and attendance. Having a well detailed lesson plan grounded in theory and research and driven by state and national standards is crucial. Stanford University and the American Association of Colleges for Teacher Education (with assistance from Pearson) developed “edTPA” (Teacher Performance Assessment) to assess teacher education programs that are in accordance with state and national standards (including Common Core State Standards) (edTPA, 2013a). The edTPA tool focuses on a teacher’s ability to demonstrate knowledge and skills essential for student learning (edTPA, 2013a). Included are specific rubrics in the areas of planning, instruction, and assessment.

In regards to health education, mastery (level 5 on edTPA planning rubrics) outlines a number of specific criteria for evaluation. Planning a mastery level lesson includes but is not limited to connections between cognitive, skill, and affective objectives (driven by state and national standards), allows for personalization, supported by research and/or theory, focuses on multiple learning styles, allows for different options to demonstrate learning, and meets the needs of different language levels (edTPA, 2013b). By focusing on culture (including multiple language levels), and utilizing a differentiated instructional approach, mastery level as outlined by edTPA can be achieved.

**Instructing**

Instructing under a CBDIM entails a variety of strategies to meet all different learners in a classroom. It starts with knowing their cultural background, learning styles, readiness to learn and then planning instruction based on this assessment. In addition, differentiating the classroom learning experience (independent work, partner, small group, etc.) is utilized.

Health education mastery level (level 5 on edTPA instruction rubrics) encompasses the following themes: opportunities addressing different perspectives, challenging content, skill, and affective objectives, student self-assessments, a variety of strategies to deliver content and practice skills, address individual beliefs, grounded in theory and/or research, and personalized throughout (edTPA, 2013b). These mastery level themes are embedded in the CBDIM. This enriches the learning experience for both the individual and the entire class through dissemination of learned material from specific cultural lenses, while allowing others to benefit from a unique cultural perspective.

**Assessing**

Formative assessment strategies are essential when planning and instructing in a CBDIM. Informal assessments of materials and procedures ahead of time are critical and allows for adjustments to be made before implementation. One example entails information gathering surveys that include learning styles, environment the student works best and other essential information.

Daily assessments and adjustments are utilized in the CBDIM. Health education mastery level (level 5 on edTPA assessment rubrics) encompasses the following themes: connections between quantitative and qualitative patterns of student learning, use of feedback, self-reflection opportunities for students, variety of different opportunities for students to display knowledge and demonstrate skills, account for a variety of learning styles, and personalized to student beliefs (edTPA, 2013b). A variety of assessments are presented for students to display knowledge and skills in the CBDIM. Individualized feedback is essential to the learning process and daily assessments provide an opportunity for this to occur.

**Level Three**

**Classroom Management**

Classroom management in the CBDIM refers to the environment where instruction, skill practice and assessments occur. As with all four components under level three, these take into consideration pre, present, and post strategies. Friedman and Abramson (2013) discussed how student success can be set up by providing learners with a path of least resistance and the instructor’s role is mainly a facilitator. Organizing the room with designated areas (materials for creativity, technology stations, mailbox system for absent students, etc.) is critical. In addition, the ability to walk around freely to assess, instruct, and provide feedback is important to the learning process. Howard Gardner spent decades researching multiple intelligences (spatial, musical-rhythmic, bodily-kinesthetic, logical-mathematical, etc.) and concluded that everyone has a full range of intelligences and no two individuals have the same intelligence profile (Gardner, 2006). A classroom environment needs to be conducive to learning and account for these different multiple intelligence makeups in each class.

Rita and Kenneth Dunn spent decades conducting meta-analysis research on learning styles. Environmental elements were one particular stimulus identified and translate to a classroom environment that takes into consideration sound, light, temperature, and seating design (Dunn & Dunn, 1993). The CBDIM incorporates formative assessments and process evaluation throughout to identifying optimal classroom environmental stimuli for students.

**Behavioral Management**

 Student readiness to learn is a key component when instructing under a CBDIM. It is critical to have strategies to handle potential behaviors (e.g. insubordination, low motivation, aggressive behavior, etc.) that arise. However, many of these behaviors can be prevented by effectively utilizing the CBDIM. Lessons individually geared toward student’s cultural background and learning style, allow for learning of meaningful material that is personalized to student interests and thus helps avoid behaviors that may occur from a different approach.

 Teaching under a CBDIM focuses on understanding culture and communication is essential when managing behaviors. Students who are most likely to dropout are unmotivated by specific lessons, their needs are not being met or may be dealing with outside influences (McWhirter, McWhirter, McWhirter, & McWhirter, 2013). From a behavioral management standpoint, there are numerous benefits to having students stay in the classroom when behaviors arise and how a teacher manages, diffuses, and redirects those behaviors plays a key role toward achieving the stated outcomes.

 Behavioral Management starts with setting up a classroom environment that is conducive to learning and then managing it in a non-threatening way. The theory of planned behavior proposes that individual behavior is determined by behavioral intentions, where these intentions are directed by individual's attitude toward the behavior, subjective norms surrounding performance of the behavior, and ease with which the behavior can be performed (behavioral control) (Ajzen, 1985). Keying on subjective norms in the students life can help identify and thus create strategies to deal with intention to commit behavior. The student’s peers, family, community members, and other important people in their life can act as partners in a collaborative approach when managing specific behaviors.

**Intrinsic Motivation**

Martin Buber (1957) discussed how active inclusion involves creating an atmosphere that allows an individual to feel important or essential to the outcome of a situation taking place. The CBDIM accounts for this key component of the learning process. By focusing on individual cultures, an educator can utilize intrinsic rewards the individual deems important, thus creating a purposeful and meaningful environment.

Extrinsic motivation is a temporary moment that soon dissipates while intrinsic motivation is a long-term investment essential to the learning process. Building on the work of Harry Harlow and Edward Deci, Daniel Pink (2009) discussed how traditional extrinsic rewards can have the opposite intended result and lead to diminished intrinsic motivation, lower performance, less creativity, unethical behavior, and short-term thinking. Teaching under a CBDIM utilizes intrinsic rewards as a motivational tool to improve performance, attendance, behavior, and increase creativity.

**Attendance Rate**

Evidence suggests there is a direct correlation between attendance and student achievement (Balfanz & Byrnes, 2012). An educator can utilize several classroom approaches, but their efforts become futile if students are not present. Therefore, a specific focus on increasing attendance rate is crucial and directly tied to the CBDIM outcomes. By starting with cultural background and then differentiated instruction, one aim of the model is to create a relevant and meaningful environment for each student, thus improving the desire to attend class regularly. In addition, a variety of pre, present, and post strategies are essential to account for this key component.

**Scope & Sequence**

The curricular scope and sequence sits above the CBDIM in phase one and is based on student readiness. This can be implemented and managed in a comprehensive fashion, but flexibility is built in to account for attendance, behavior, and other barriers to learning. A multiunit curriculum designed to build on each other can still be accomplished by having students complete the lessons in order as intended. If a barrier presents itself (student absence or behavior issue) and a lesson is not completed for that day, under the traditional model a student would fall behind, thus playing catch up the rest of the way. Under the CBDIM all lessons can be completed individually without needing past material.

Students who have past material will be cued to incorporate prior knowledge into the lesson. Students without this material will be briefed on how the current information will be utilized in future lessons. This sets the stage for the future lesson, allows the student to feel they are still with their classmates, thus encouraging an environment where students begin to attend class regularly. Strategies are then employed to catch students up on missing assignments through independent studies, online, culminating projects, etc. In addition, the community outreach component (as discussed in the next section) provides an avenue for comprehensive learning. The scope and sequence must “float” across the top of the model to account for barriers to the learning process. By understanding culture, these barriers can be reduced and/or eliminated and by utilizing a differentiated instructional approach, the scope and sequence can be completed in a comprehensive manner.

**Phase Two**

**Community Outreach**

The CBDIM utilizes a community outreach component to learn, disseminate, and teach knowledge, skills, and value. It has long been established that many students learn by doing (Dewey, 1938). Community outreach serves multiple purposes and provides a forum for students to become teachers. Simply expecting to teach has shown to improve student learning (Nestojko, Bui, Kornell, & Bjork, 2014).

Current immigration concerns coupled with existing multicultural neighborhoods, present a scenario where potential language barriers and other needs will continue to exist. School aged children serve as important catalysts when working with multicultural groups. This provides a unique opportunity where students and the community, partner in the learning experience. Learning by teaching is an effective strategy that allows students to apply knowledge and skills and helps them retain information (Ketmao, 2014). In addition, they reap the benefits of formative assessment strategies as they now become the disseminators of information. Recursive feedback occurs through assessing and observing pupil’s use of knowledge and skills they have been taught (Okitaa & Schwartzb, 2013). The students now benefit from recursive feedback they receive from teaching knowledge and skills to family and community members.

The CBDIM allows for cultural needs to be prioritized and students play the dual role as learner and teacher. This presents itself in a variety of forms. For example, student assessments can serve as important materials to disseminate information. Pamphlets, posters, projects, billboards and other materials students create to display knowledge and practice skills in class can be used for this purpose. Differentiating this component is essential, but the process of working back and forth with the community is critical to student learning.

**Phase Three**

**Outcomes**

The CBDIM was designed to target school, community, and health related behaviors. School related behaviors consist of conduct, performance, retention, and graduation rate. Community behaviors include empowerment, autonomy, self-efficacy, and quality of life. The final outcome focuses on health related behaviors and these will vary depending on the community. However the U.S. Department of Health and Human Services (HHS) provides resources on health related behaviors to target. While these are good starting points, it is critical to conduct a proper assessment of the community. Local health departments and coalitions provide resources and data to determine the most prevalent health issues. These can then be prioritized when developing the scope and sequence curriculum component in phase one of the model.

The HHS (2015a) under its “Healthy People” initiative, provides ten year health objectives and goals for all Americans with a focus on disease prevention. These national objectives have helped establish monitored benchmarks to assess progress for the last three decades. In addition, HP aims to encourage collaboration across communities, empower individuals, and evaluate prevention efforts (HHS, 2015a). The current HP 2020 vision is for all people to live long, healthy lives. In addition, some overarching goals are to eliminate health disparities and improve QOL across all life stages (HHS, 2015a).

Healthy People 2020 covers 42 topic areas (ranging from chronic diseases to nutrition and physical activity) with over 1,200 objectives. Progress reports are released frequently outlining the “Leading Health Indicators”. Using current technology, the program maintains an interactive website for collaboration and dissemination of materials, data, and resources. For each of the 1,200 plus objectives, there is a baseline measure, separate reliable data source, and target for improvement to be met at the end of each ten year initiative (HHS, 2015b). These objectives were developed by experts from leading federal agencies and presented to the public for feedback. Most objectives are geared toward interventions to reduce or eliminate illness, disability, and premature death among individuals and communities with broader objectives such as eliminating health disparities (HHS, 2015b). This provides a valuable resource when addressing health related behaviors in schools and local communities.

Assessment throughout implementation is crucial to achieve the stated outcomes. The model is broken down into three major forms of evaluation. Phase one utilizes formative assessment strategies during development of culture based lessons. Process evaluation strategies are ongoing, starting in the formative evaluation phase and continue through summative evaluation. Phase two consists of impact evaluation strategies tied to community outreach. Phase three entails summative evaluation to assess school, community and health related behaviors. The model is being illustrated from a health education standpoint at the high school level, but can be adapted to other content areas and multiple learning levels (K-12, college, older adults, etc.). As stated earlier, education levels have a direct impact on the stated outcomes.

**Start Points for Application & Implementation**

The CBDIM focuses on the area school system as a starting point followed by the surrounding community. However, it is in the interest of the health education specialist to assess the community during the formative evaluation phase and infuse and prioritize the most prevalent health issues into the scope and sequence when developing curriculum. The community outreach component serves multiple purposes, one of which is to bridge the local schools and community together in a collaborative approach. Again, the community outreach component serves as means to disseminate information and enrich the learning experience for all stakeholders involved. In addition, students are best equipped to communicate and gain the trust of a community consisting of their friends, family and acquaintances. This provides a potential unique scenario where students are a go between and the community is being educated parallel with the local schools. This has the possibility to be extremely cost effective as well.

Once phase one has been fully developed, community outreach (outlined above) can be implemented throughout the class experience. Students can disseminate information and teach skills on a weekly basis to family, friends, and community members. By assigning specific projects with measurable objectives, an instructor can assess student progress and gather valuable information from the corresponding community. This can lead to empowerment for the students (as they grab the reins and become the authoritative figure) and the community as they learn value knowledge and skills.

Phase three can be measured in a variety of ways. School related behaviors can be assessed by measuring attendance, performance, retention and graduation rates from a CBDIM health education class and comparing it to past sections of the course that was taught using a different approach. If other classes and subject areas implement this model, the results can be assessed in a similar way. A survey given to families and community members before the class starts with questions addressing the stated community related behaviors and then a follow-up survey at the end of the course can be used to evaluate community related behavior.

 The Youth Risk Behavior Survey (YRBS) was developed by the CDC to monitor health risk behaviors and is administered to 9th through12th grade students every two years in the USA (CDC, 2015). This can be used to measure the health related behavior change component on the model. Data collected from this survey on students who have gone through a health education course being taught under the CBDIM can be compared against students from other area and national schools. In addition, health related behavior change can be evaluated using a pre and posttest and by analyzing trends and data gathered by the local health department.

**Conclusions**

This model was designed as a framework to account for and utilize multicultural learners, partner with the community during the learning process, and to address school, community and health related behaviors. It is recommended health education specialists are at the forefront when developing and implementing this approach, but other content areas and different level learners can also benefit from this model. Future research studies by the author are planned, focusing on achieving the stated outcomes for students and the residing community. The author invites researchers to partner with to address the following populations: at-risk school districts, multicultural school districts/communities, schools on state need of improved lists, low performing schools, and districts looking to improve student behavior, retention, performance, and graduation rate while improving different facets in the corresponding community.

Clinical practices and public health organizations may also benefit from using this model. Organizations interested in targeting specific health behaviors or conditions (obesity, chronic diseases, sexually transmitted infections, etc.) may wish to partner with a local school district when targeting a community. While it is vital to collaborate and combine resources, utilizing students during community outreach can be effective when working with different cultural groups.

The aim of this article is to simply introduce the model and provide brief justification for each component. The objective was not to provide a detailed curriculum and program. Instead, the main purpose was to provide framework for curriculum development (and areas to account for) along with utilizing a different approach to learning and addressing a corresponding community (through the use of community outreach). Future research studies are planned using the model to measure the degree of effectiveness, provide more detailed discussion on application and implementation, and identifying barriers and limitations.

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**Figure 1**

**Attendance Rate-**

**Level 3**

**Assessing- Level 2**

**Intrinsic Motivation- Level 3**

**Behavioral Management- Level 3**

**Classroom Management- Level 3**

**Planning- Level 2**

**Instructing Level 2**

**Culture-Based Differentiated Instruction- Level 1**

***Phase 2***

***Phase 3***

***Phase 1***

**Scope & Sequence**

**Community Related Behavior**

**\*Empowerment**

**\*Autonomy**

**\*Self-efficacy**

**\*Quality of life**

**Formative Evaluation**

**Impact Evaluation**

**Summative Evaluation**

**Health Related Behavior Change**

**Community Outreach**

**Graduation Rate**

**Retention Rate**

**Performance**

**School Related Behavior**