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Cultural Competency: A Viable Approach to Health Disparities in Urban Schools

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This paper encapsulates a large body of work on cultural mismatch, cultural competency and their interrelation with health disparities in urban schools. Cultural mismatch is the cultural difference between formal institutions and the populations they serve, while cultural competency is defined as the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services (Cross, 1989). As noted in this paper, disparities include the racial, economic, and cultural issues affecting the health of school age children. Using cultural competency as a theoretical framework, this paper discusses the implications of cultural competency for health outcomes in urban schools.

In 2001, 19% of children residing in the United States lived with at least one foreign-born parent (American Academy of Pediatrics, 2007). Between the years 1990 and 2000, the number of immigrants in the United States increased by 50% (U. S. Immigration and Naturalization Service, 2000). Moreover, the American Academy of Pediatrics projects that by the year 2025, children of color will comprise 47.4% of the population under 18 years of age. According to the Institute of Medicine (2003), racial and ethnic minorities receive lower quality healthcare as compared to their white peers, even when researchers control for healthcare coverage and access-related factors such as ability to pay. Further, research suggests that bias, prejudice, and stereotyping contribute to this disparity (Institute of Medicine, 2002). Over 40% of school health professionals surveyed by the Center for Health and Health Care in Schools report that their health programs are affected by cross-cultural issues (Center for Health and Health Care in Schools, 2007).

Similarly, the Office of Minority Health (2007) notes the following challenges for communities of color:

- In 2003, tuberculosis was 21 times more common among Asians, as compared to whites.
- American Indians and Alaska Natives have an infant death rate almost double the rate of whites.
- American Indians and Alaska Natives are two times as likely to have diabetes as whites.
- Hispanics have higher rates of obesity than non-Hispanic whites.
- Hispanics accounted for 18% of HIV/AIDS cases in 2004.
- In 2003, the death rate (by diagnosis) for African Americans was higher than whites for: heart diseases, stroke, cancer, asthma, influenza, pneumonia, diabetes, HIV/AIDS, and homicide.
- African American infants are nearly 4 times as likely to die from causes related to low birthrate, compared to non-Hispanic whites.

Purpose and Background

This paper encapsulates a large body of work on cultural competency and its interrelation with health disparities. These disparities include the racial, economic, and cultural issues affecting the health of school age children. Using cultural competency as a guide for ensuring responsive practice, this paper examines the conceptualization of cultural competency and its implications for health outcomes among youth in urban schools. In particular, we attempt to make two central arguments related to health outcomes and cultural competence:

- Curriculum can be designed to help students understand health disparities and to encourage students to make healthier choices; and
- Schools can be used as vehicles to treat health disparities—where physicians are actually in schools to treat students who are ill.

These arguments are grounded in what is defined as cultural competence. Cultural competency is an active process, an ongoing pursuit of self-reflection, knowledge acquisition, and skill development practiced at individual and systematic levels, with the aim of effectively engaging culturally diverse populations. It is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross, 1989). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and

groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services—with a goal being to produce better outcomes for a cultural group (Cross, 1989).

Adopting a culturally competent approach has promise as the National Center for Cultural Competence (2005) provides the following six-pronged rationale for the importance of culture competence in healthcare:

1. Perception of illness, disease, and their respective causes differ by culture.
2. The belief systems respective to health, healing, and wellness, typically vary.
3. "Help seeking behavior" and attitudes toward healthcare providers are influenced by culture.
4. Individual preference is a significant factor in traditional and non-traditional approaches to healthcare.
5. Personal experiences with bias are a barrier to accessing health care systems that must be overcome by patients.
6. Culturally and linguistically diverse health care providers are underrepresented in current service delivery systems.

Indeed, cultural competency is a multidimensional construct and adopting a culturally competent approach to addressing health disparities is a paradigm shift from a traditional American healthcare model. The current administrative framework in many schools is not designed to effectively implement such an approach. In many instances, school staff and faculty have not had the required professional development to recognize contributing factors to disparities or identify the physical and mental needs of students of color in the curriculum. Certain behaviors may go unnoticed or unresolved due to lack of cultural understanding or cultural incongruence. Thus, it is imperative that teachers, counselors, school psychologists, school social workers and administrators become familiar with and endorse the concept of cultural competency in order for it to effectively address health disparities.

Cultural Competency and School Health Issues

It is critical to the future health of minority school age children that educational administrators, staff, and families aggressively work toward the expansion of the role of schools in supporting the physical and mental health of children. The traditional physical health and educational model must be replaced with a comprehensive, culturally competent health care program that effectively addresses the current health disparities existing in this population. Quantitative data objectively illustrates the current disparate state of health status among school age children. Typically, studies examine or recite factors such as race, ethnicity, genetic predisposition, socioeconomics and cultural beliefs as contributing factors to the health disparity that exists between minority and majority subjects. Rarely, is there an examination of the fact that the one institution in the United States that supports children and pursuant to the laws of most states, is mandated to be involved in a child's life from age four to eighteen in most cases, has failed to establish an adequate system to address health disparities when they first emerge as identifiable factors. Schools are well-positioned to detect those factors that have been widely identified as early predictors of suboptimal health conditions; intervene to teach children to recognize and effectively manage or eliminate the factors; monitor progress; and provide reinforcement. The compulsory nature of school, the tracking of indicators like attendance and performance in schools, as well as the proliferation of school-based intervention, afford schools opportunities to identify and address suboptimal health conditions. One case in point is the Fellows Academy.

The Fellows Academy is an ongoing partnership between a large urban school district, a workforce development agency, and an intermediary specializing in school-based wraparound services. Two hallmarks of this specialized intervention program are holistic client-centered programming and culturally competent practice. Using an accelerated learning model as a framework, the school district's core curriculum serves as the foundation of the Academy's curricular program. However, the district's curricular program is supplemented by the workforce development agency with a leadership and character development program emphasizing health and wellness, coping, anger management, and refusal skills. Further, subsequent to each instructional day, program participants receive individual and/or group counseling from interns who have been trained in the tenets of culturally competent practice.

In addition, each participant is assigned a case manager, who reinforces the concepts presented during instruction in weekly case management appointments, while attending to the dynamics of cross cultural communication and interpersonal relations. Further, as a part of the Academy's intensive case management process, performance and attendance data are collected at weekly intervals. Using this data as a guideline, students presenting

with low task completion, incidences of disciplinary referrals, excessive absences or tardies are referred to a weekly case management team meeting. Students also may be referred for significant changes in their family system, level of coping or functioning, and life events, such as loss of family members, employment, or residence, and health concerns.

During the weekly case management team meeting, case presentations are presented to a team comprised of case managers, instructional staff, and management. The composition of the weekly case management team is designed to facilitate continuity across case management and lesson planning, while ensuring comprehensive service provision. The team generates a list of recommendations, referrals, or services that are subsequently compiled in a case plan and/or reinforced during the school day.

In addition to intensive remediation, specialized educational programming, and intensive case management, Fellows Academy participants receive wraparound and supportive services to assist in mitigating barriers to school success. These services typically include free dental and health services, clothing and transportation vouchers, and utility payment assistance.

The results of a recently conducted mixed method program evaluation examining the fidelity and efficacy of the Fellow Academy Program indicate the program significantly increased rates of course completion and matriculation for program participants (Sterling, Tyler, Cleveland, and Thompson, 2009). Moreover, as the program continues, it has adapted to address the unique needs of its participants while maximizing the resources of its partners. Resultantly, the Fellows Academy represents a great example of how school programs can be modified to operationalize cultural competent approaches, while addressing the health needs of youth in schools. Further, its potential benefits for students represent a significant buy-in for schools.

It is clear that children who may not have access to primary healthcare and or have the parental support to access a provider for preventive healthcare do have access to a free public education. Whether the failure to establish within our school systems comprehensive health programs that address disparities and intervene to mitigate early identifiable risk factors is a result of a lack of expectation by the public, lack of commitment by policy makers or lack of resources is beyond the scope of this review, that is focused on identifying the existence of health disparities in school age children and establishing the need for a culturally competent approach to addressing the disparity.

Health Disparities in School-age Children

The Institute of Medicine (2003) defines health disparity as a difference in the quality of healthcare provided to people because of their race or culture. Examples of health disparities include disparities in diagnosis, including, but not limited to: cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness. The National Institutes of Health (2002) defines health disparity as the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse conditions that exist among specific population groups in the United States. It is critical to the future health of minority school age children that current educational administrators aggressively expand the role of schools in supporting the physical and mental health of children. The traditional physical health/education model must be replaced with a comprehensive, culturally competent health care program that effectively addresses the current health disparities existing in this population.

Evidence illustrates the current disparate state of health status among school age children. Typically, studies examine or recite factors such as race, ethnicity, genetic predisposition, socioeconomics and cultural beliefs as contributing factors to the health disparities that exist between minority and majority populations. Schools could be well positioned to detect factors that have been widely identified as early predictors of suboptimal health conditions and health risks. In the curriculum, schools and teachers could teach children to recognize and effectively manage or eliminate factors leading to health risks, could perhaps monitor progress and decision-making of students, and provide reinforcement. It is clear that while some students do not have access to primary healthcare, they do have access to a free public education and schools can serve as a catalyst to help ensure that all students receive the healthcare they need and deserve.

Studies have well documented the fact that there is a disparity between the health profiles of minorities versus that of whites. That health disparity emerges at a young age and continues throughout adulthood. Minority children experience higher rates of mortality (Wise, Kotelchuck, Wilson, & Mills,1985); disability (McCarty & Levine, 1999); obesity (Ogden, 2006); diabetes; asthma; and prevalence of HIV/AIDS (HLaing & Darrow, 2006) than their white counterparts.

The focus of discussions relative to health disparities has been concentrated, in part, on health conditions that adversely impact the health status of minority children. An array of factors contributes to health disparities such as racial, genetic, socioeconomic, and cultural beliefs. Moreover a confluence of these factors can and often does

lead to a reduction of a child's health status. According to Evans and Stoddard (1990, p. 1358) these factors run together and can truly be instrumental in the health of children (see Appendix).

The challenge for school officials in developing a culturally competent program for addressing health disparities is in first, isolating and identifying those factors that are reliable predictors of future health challenges. For example, the level of education attained by the parents of school age children can be a predictor of the general health of a child. Studies have shown that parents with lower educational levels tend to have children that are more likely to become sick than the children of parents with higher levels of education. Similarly, the eating habits and lifestyle choices of low income, minority children have been identified as factors leading to childhood obesity. Further, childhood obesity among African American children, specifically, can be used as one of several factors indicating a predisposition to diabetes. Racial and ethnic minority children are more likely than white children to have problems with access to care, number of physician contacts, and frequency of unmet health needs (Weech-Maldonado, Morales, & Spritzer, 2001). Whether the factors are genetic, such as a predisposition to diabetes which is prevalent in the African American community; related to socio-economics --a lack of resources and limited access to quality healthcare or nutrition; or a function of limited education-- not knowing the importance of healthy choices, a strong culturally competent approach to intervention is driven by the matrix of all of these factors. Schools servicing culturally identifiable populations can be positioned to intervene at the point of identifying a significant combination of risk factors in a child's health profile. Factors that contribute to a child's health status are often ignored by school officials because well established assumptions about certain identifiable populations have not been previously utilized to establish a paradigm for addressing health issues in a school setting.

A comprehensive, culturally competent health care approach, focused on health promotion and disease prevention is critical to improving the quality of life for minority school age children and eliminating long term health disparities. Early intervention during the school age years provides an early opportunity to divert the onset of adult health challenges. There is a prevalence of cardiovascular disease, hypertension and diabetes in adult African Americans that has been shown to disproportionately lead to death (Collins, 2006). Educators must understand the value of information that they are privy to as part of the one institution that has consistent contact with children and their families from childhood to adulthood. Teachers and administrators gain first hand knowledge of the presence of factors that serve as predictors of poor health and are positioned to develop and assist in the implementation of corrective action plans to reverse the patterns that lead to lifelong health disparities. Teachers and administrators are the daily observers of their students' environments, lifestyle choices, objective health measures (e.g. weight, height, physical ability/ activity), general health and well being. The difference between being a passive observer of apparent disparities and an advocate for eliminating those factors that if unchecked will lead to lifelong health disparities is in the development and implementation of a program that supports the health of children, incorporating a culturally competent approach.

Cultural Competency as a Viable Approach

In response to the pervasive disparities across domains and institutions, cultural competence has emerged as a viable approach to mitigating the barriers that result in inequity (Betancourt, Green, Carrillo, and Ananeh-Firempong, 2003). Cultural competency is of particular importance for schools. As a social institution, schools are sites of the greatest amounts of diversity – by race, class, and gender. Developing personnel that are responsive to the needs of diverse learners has major implications for academic and health outcomes. Although all related, cultural competency, cultural diversity, cultural awareness, and cultural sensitivity are distinct constructs. Cultural competency is an active process, an ongoing pursuit of self-reflection, knowledge acquisition, and skill development practiced at individual and systems levels, with the aim of effectively engaging culturally diverse populations. Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross, 1989). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby, producing better outcomes (Cross, 1989).

Schools should continue to develop, implement, and evaluate culturally competent strategies in an effort to reduce health disparities. Health disparities exist among minority children in death rates, obesity, type 2 diabetes, and in the prevalence of HIV/AIDS. There are several factors which contribute to health disparities, including but not limited to, income level, parent educational level, environmental conditions, and access to quality health care.

Conclusion

Adopting a culturally competent approach to addressing health disparities is a paradigm shift from the traditional American healthcare model. The current administrative framework for secondary schools is not designed to effectively implement such an approach. In many instances school staff and faculty have not had the required professional development to recognize contributing factors to disparities or identify the physical and mental needs of students of color. Certain behaviors may go unnoticed or unresolved due to lack of cultural understanding or cultural incongruence. It is imperative that teachers, counselors, school psychologists, school social workers and administrators become familiar with and endorse the concept of cultural competency in order for it to effectively address health disparities. Clearly, the current system and approach to health is resulting in disparities that are identifiable early in the lives of children. Studies have reliably isolated the factors that with a great degree of scientific certainty can be attributed to predetermining the health disparity that currently exists. It logically follows that the approach to eliminating the health disparity should begin with the most effective means of eliminating those identifiable factors.

It is equally apparent that any organization, public or private, must be value driven in order to be effective and efficient and there is increasing recognition that cultural competence must be one of those values. Successful service oriented organizations, from the leadership to the direct service providers, seek collectively to understand the cultural background and the specific needs of their clients, then develop or modify programs and services to consistently reflect that understanding. The challenge for schools is to create an environment that provides a means to formally recognize and foster the understanding and appreciation of cultural competency.

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