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Identifying Disparities: One Student's Journey Through Western North Carolina with the CHA

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Abstract

Every four years, the Buncombe County Department of Health and Human Services conducts a community health assessment (CHA), which serves as "the foundation for improving and promoting the health of county residents." The current public service project grew out of a service-learning assignment in a course, to assist in the data collection for the CHA. In support of this important community asset, this student was assigned to the Pilot Buncombe County 2012-2013 community health assessment in block groups 28806 and 28715. The project activities include coordination of data collection, training surveyors, analyzing the data, and providing a supplemental report of the findings, serving in tandem with the Regional CHA. The report will enhance and clarify understanding of the health disparities within Buncombe County. Working on this project has broadened this student's understanding of the health and social determinants at play within Western North Carolina and heightened this student's resolve to find creative ways of addressing them to reduce health disparities and improve population health.

Key Words: Community Health Assessment, Health Disparities, Health Department, Social Determinants of Health

Origins of the Project

The evolution of this project with the Health Department first emerged from my academic experience in the UNC Asheville Health & Wellness Promotion class Health Disparities, taught by Dr. Ameena Batada. As students, we had the opportunity to participate in various community and civil service projects. I chose to work with the Buncombe County Community Health Assessment (CHA). Orientation for the Health Assessment was centered on how to properly conduct surveys (techniques, methods and process) and how to interact with the population/community. The health department representative, Marian Arledge, presented on the importance of conducting a community health assessment, its function within the county, and the value it holds as a resource to county officials in identifying a range of health disparities. Marian Arledge identified the regions participating in the community health assessment as both west Asheville (28806) and the Enka/Candler (28715). While I have lived in Asheville for 7 years, I have never explored these communities beyond the confines of Patton Avenue (Main Street) and Smokey Park Highway. I was immediately enthusiastic to have the opportunity, as a health promoter, to explore the more rural regions of western North Carolina and talk to the community about their health and other pressing concerns.

The experience of conducting a community health assessment proved pivotal in my life; the CHA left an indelible mark on my psyche and helped shape my understanding of the social gradient of health. After finishing my initial commitment with the health department for Dr. Batada's class, I realized the health assessment had yet to survey 130 houses. Working with the CHA had a profound impact on how I viewed Asheville and I felt pulled to continue working with the project. I approached Marian Arledge in the summer of 2012 about the possibility of an internship position with the CHA. Marian spoke about the shortage of assistance from the Health Department staff in conducting the CHA and welcomed me onto her team.

The Global Health Governance identifies health as "a universal aspiration and a basic human need." Furthermore they state, "the development of society, rich and poor, can be judged by the equality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from the disadvantaged as a result of ill health" (Bell 478). My internship was an opportunity to explore the social determinants of health, first-hand, and grow in understanding of the issues facing different populations. I believe strengthening health equity demands a creative, multifaceted approach and that the CHA is the foundation (identifier) to such work. The CHA represents an element of civil service, whereby I am engaging with the community (as a citizen), surveying the status of health in the community (stakeholders) and presenting the findings to the county. The CHA is a powerful tool to motivate and influence stakeholders to mobilize action towards implementation of future health equity endeavors. Marian Arledge identified early on the need for finishing the community health assessment and presenting a report of the findings to serve as a supplemental report to the 2012-2013 regional CHA findings. The project of the Community Engaged Scholar shifted and morphed through several different incarnations until it finally arrived

at the stage of creating a *supplemental report* and finishing the rest of *the block group surveys*.

At first, Marian Arledge and I imagined developing a project that involved social media and an online training tool for the CHA. I would create a video manual on how to properly conduct the CHA survey that could be passed onto future generations of surveyors. The idea behind this was that the training process was so demanding (for Marian Arledge) anything that minimized the effort (output) on the end of the health department training sessions would be a success. As time continued, however, the reality of the situation began to emerge, and our plans shifted. At the close of the summer, 2012, we still found ourselves with 80 houses left to survey in 28806. We reassessed our position and intentions for the CHA and decided that the single most important aspect is finishing the CHA and producing a supplemental report of the findings. In our report, we hope to outline clearly the health disparities impacting the region and identify any discrepancies between the regional report and ours. In *Community Health: An Evolutionary Concept Analysis,* Mary Jo Baisch asserts that "dynamic and contextual, community health is achieved through participatory, community development processes based upon ecological models that address broad determinants of health" (Baisch 2464). Our focus is to have the supplemental CHA report, along with the regional health assessment, promote action on the community and county levels, within hospital systems and the public health sector. Ultimately, the CHA works towards the advancement of health within the community.

Methods and Work Undertaken

While my roles took on many forms during the community healthy assessment, my priority was always *surveying* the community. This has been and remains my priority for the community health assessment. A community health assessment involves many levels of attention and demands a multitude of players to make it happen. This is why it was a priority early on for the Buncombe County Health Department to have a partnership with UNCA Health and Wellness students and Mars Hill College Social Work students. The partnership provides powerful human resources (students) to participate in the data collection process, a demanding and difficult undertaking. The amount of preparation and planning that is required to conduct a single weekend CHA is staggering. My responsibility as the co-coordinator for the community health assessment, and my Public Service Project grew to involve the training of students on how to conduct a health assessment. Similar to my own introduction to the CHA through Dr. Batada's Health Parity class, I was put in charge of training students from the summer 2012 UNCA Health Parity class and the Fall 2012 Mars Hill Social Work students to participate in the CHA.

Training Student Surveyors

Marian Arledge and I approached the teaching process together as a team. We split the responsibilities in half and covered distinct portions of the CHA. I was mostly responsible for the process of how to properly "interview respondents" and taught

protocol for "conducting the survey properly". I prepared a PowerPoint for the Health Department that outlined the most effective methods of interviewing. The slides focused on the importance of remaining neutral during the interview, how rapport is developed and trust is accrued, but most importantly how data is collected without bias or personal manipulation (often unconscious). We taught that as a part of the Patient Protection and Affordable Care Act, a private nonprofit hospital is required to complete a community health needs assessment to maintain its tax-exempt, 501(c)(3) status; this requirement applies to tax years beginning after March 23, 2012 (every 4 years).

This new requirement provides an opportunity for CHAs to engage their local community members to participate and work toward community health. Mary Jo Baisch reveals "community health differs from a 'healthy community' in that community health is a dynamic and evolving process, while a 'healthy community' is a state of being. Community participation creates the dynamism in the process" (Baisch 2467). This idea of community-based action is aligned with the values outlined in the WNC Healthy Impact organization. The WNC Healthy Impact was a valuable resource we utilized in conducting the CHA. This organization identifies their mission as "a partnership between hospitals and health departments in western North Carolina working towards a vision of improved community health" ("Home"). They strive to promote, locally and regionally, a "community health improvement process to assess health needs, develop collaborative plans, take coordinated action, and evaluate progress and impact" ("Home"). The WNC Healthy Impact provided resources to previous health assessments and gave insight into what to expect and how to effectively run a CHA. The next most significant portion of the training process with the students was covering the GIS data-recording device, entitled the *Trimble*.

The methods taught during the PowerPoint presentation to the UNCA and Mars Hill students included the teaching of protocol and understanding of the *Juno ST Trimble* hand-held data collection device. This small item is responsible for holding the data from the surveys and triangulating the position of the house in relation to the whole community. It is a product from the 1990's and has a few glitches that continually inhibit use and function. In essence, the Trimble is similar to a portable computer. We have a program written specifically for the CHA, where by every one of the 60 questions from the health assessment surveys are entered into the Trimble. After asking each question, a drop-down menu bar provides the answer key for the student to enter the data in real-time. As a CHA coordinator, it was essential that every student understood the mechanics of the Trimble, as well as how to properly enter the address, data results, and how to shut down the mechanism (at the risk of losing data). After the student groups conducted their surveying sessions, I collected the Trimbles and returned them to the I.T. Technician in the Health Department to be uploaded onto the community health assessment database. From here, the I.T. technician could pull up maps of the county and insert the data, manifesting a visual representation of health within a community and the subsequent location of certain health disparities. By the latter portion of my work with the CHA, the Trimble became obsolete, and we switched to manually entering the data onto a computer. In addition to the training about the Trimble, we were also responsible for educating students on the survey.

We discussed the formatting, flow and order of the health questions within the survey. We explored possible answers commonly given by respondents and the most likely questions they would ask of the interviewer. An exciting aspect about my experience with the CHA was how the survey underwent many stages of edits. If a student surveyor had trouble with a certain question, or felt uncertain about another's wording, they could approach Marian or myself and recommend an edit. As the World Health Organization states "a community health needs assessment is not a one-off activity but a developmental process that is added to and amended over time. It is not an end in itself but a way of using information to plan health care and public health programs in the future" (WHO 1). After educating the students about the survey and the Trimble we covered the principle of "going to the left." As simple as this idea appears to be, it caused great confusion and frustration amongst students and staff. A significant portion of any survey is *continuity.* The value of the data is derived from the consistency of the surveyor and the protocol followed. 'Going to the left' is one such example because it ensured the randomness of our work and inhibited bias. We teach that surveyors should continue going to the left if residents don't answer or are unavailable. We instruct students to continue going to the left until they are able to interview an individual. A common mistake made was that after several attempts of going to the left, students would just give up and go to the next house on the list. Random allocation ensures no systematic differences are applied, known or unknown, that may bias the results. For each block group, we divided the students so that every pair was responsible for 10 houses total. We crafted a cover letter outlining the original destinations for the students then added a column identifying "the actual address collected." This provided us the ability to return later and pick up the CHA process where one student may have left off. Unfortunately, if students decided to skip a house and travel to the next group, we would have to eventually send out a surveyor back the next week and pick up where they left off.

In total, we trained three separate classes/groups of student surveyors. We organized the student groups into parties of two, one student "interviewer" and the second student "data recorder/collector". We crafted spreadsheets of 'availability' of students and organized weekend CHA dates. Part of my job required communication with the Buncombe County Chief of Police, making reservations for escorts to coincide with the availability of the student surveyors. The police would follow the students around from house to house. Contact information was handed out in the beginning of the day and at every house a student would enter (or knock) they were responsible for texting the police officer their location. We worked to achieve a level of safety with all of our CHA sessions. We employed multiple permission forms that every student was required to fill out in order to participate. Nonetheless, this did not lighten the load of responsibility I felt for the security and safety of every student during this endeavor. Our sample design was chosen by the county to be 28806 and 28715. Compared to previous years' surveys that completed only a total of 100 house surveys, our 2012-2013 block groups had 130 (plus) projected respondents in each section. A computer mapping system randomly generated every address.

Simultaneously, as we conducted our CHA survey, there was the regional health assessment being conducted via phone, which included Buncombe County residents. Occasionally our surveying would overlap, and we would interview the same individual. As outlined in the regional health assessment, we strived to eliminate potential errors (non-coverage, sampling, and measurement error). Measurement error occurs when "responses to questions are unduly influenced by one or more factors. These may include question wording or order, or the interviewer's tone of voice or objectivity" (Regional CHA). Sampling error occurs because estimates are based on only a sample of the population rather than on the entire population. Generating a (random) sample that is both representative and of adequate size can help minimize the consequence of *sampling error*. Sampling error, in our situation, is further minimized through the strict application of our administration protocols. The larger the data pool the stronger the conclusions that can be drawn. The actual process of engaging the populations proved a time consuming mission. We would start our day at 9:00am and finish around 3:00 or 4:00pm. On average the students would return with 3 to 4 finished surveys. The cover sheet outlining the addresses attempted and addresses surveyed often highlighted the difficulty of our process. Some of the students recorded attempting 20 plus houses before they actually interviewed a resident. Most of the CHA was given out on Fridays, Saturdays, and Sundays. Every survey was conducted on a cold-call, meaning the individuals had no prior knowledge of the CHA happening. We did not promote this information to the community beforehand, and as a result of the computer generated randomness, and the fact that we were spread over such a great distance, neighbors would most likely not contact neighbors and notify them of the potential for a health survey. Community health assessments are a means of identifying and describing community health problems, gaps and strengths in services, and interventions to improve the health of the community. After the information is inserted into a spreadsheet, we are able to analyze the data by looking at the frequencies of respondents who have certain health conditions and practice certain health behaviors.

Ties to Academia

As Health and Wellness Promotion majors, we understand the marked link that connects health to social justice. In the academic setting of UNCA, we explore the social determinants of health and the conceptual frameworks for addressing them. The strength of the community health assessment is that the researchers have equal vested interest in the outcomes of the study. This is similar to the academic research technique known as community-based participatory research. The premise of this style of research is built upon the idea that there exists an inherent power dynamic between the observer and the observed with traditional research methods. Therefore, in community-based participatory research, we work to involve stakeholders and encourage the civic engagement of community members to achieve a collective goal. This symbiotic relationship is at the core of the community health assessment. One of the most important elements of health that we are gaining understanding about is the role of *community.*

Community has the potential to act as a positive health agent, promoting participation and control and "raising the fundamental issues concerning the priorities, effectiveness, and

accountability of services" (Hatch 224). The process of a community health assessment, similar to community-based participatory research "1. Recognizes community as a unit of identity, 2. Seeks to identify and build on the strengths, resources, and relationships that exist within the community, 3. Facilitate collaborative partnerships in all phases of research, 4. Integrate knowledge and action for mutual benefit of all partner, and 5. Promotes a co-learning and empowering process that attends to the social inequalities" (Barbara A Israel et al. 178-79). This methodology of community-based research is the product of modernity and the inherent inequities that emerged from urbanization in the early 20th century. As author John Hatch reveals, "Urbanization exacted an almost immeasurable toll from the urban newcomers…. The social and psychological costs have been staggering" (225). The impact of urbanization continues to reverberate through American society and appears in the form of co-morbidities and social determinants of health. This motivates my desire to continue in the field of public health and strive toward health equity.

In the 2010, CSDH recommendations for Global Health Governance list recommended 'areas for action' in addressing health inequities. They reveal that three dimensions of empowerment underpin the social determinants of health approach: material, psychosocial and political empowerment. They state, "People need the basic material requisites for a decent life, they need to have control over their lives, and they need political voice and participation in the decision-making processes" (GHG 479). They continue by stating, "Although individuals are at the heart of empowerment, achieving a better distribution of power requires collective social action- the empowerment of nations, institutions, and communities" (GHG 479). The foundation to our understanding of public health is the understanding that specific conditions of daily life, coupled with the distribution of power, money and resources all work together towards the stratification of health outcomes. The Global Health Governance asserts, "Relative social status and discriminatory or exclusionary processes underlie inequities in health outcomes. Participation by communities and civil society in decisions that affect their lives is central to building health equity" (GHG 479).

The CHA is a tool that identifies health disparities in the community and works to identify the concerns of populations, which are in greatest need. The health assessment applies the principals of equity and social justice by striving to ensure that resources and focus will be allocated to the populations that can receive maximum health benefits. The public health community of Thailand has an appropriate phrase they use to succinctly describe the process for addressing social justice issues: "the triangle that moves the mountain" (GHG 483). The corners of the triangle represent 'knowledge', 'social movement', and 'political involvement'. These all "work together to promote action on the social determinants of health to tackle 'the mountain of health inequities'" (GHG 483).

The strength of the community health assessment is that it works to identify the social, economic and cultural factors that impact health, and in turn positively shape our individual behaviors. During the creation of the CHA survey, we considered several tiers of health and wellness and their weight and implications. These factors are aligned with

the knowledge we explore in academia about the determinants of health and their inherent interconnectedness. While we recognize the importance of community in achieving any new health behavior change, our health assessment was missing a few important elements that are required for a *true* example of community-based participatory research (CBPR). For CBPR to truly be applied to the CHA, it would appear different than our rendering of it. In true CBPR, the community would determine the formatting, design, methods and analysis practices utilized. The community would also determine all aspects of the survey, content and implementation and the subsequent function/utility of the data once it was finished. In our circumstance, I represented the community but served as part of the Health Department. Although our intentions are closely aligned with CBPR, there is yet room for improvement. With any survey, the questions are designed to learn more about specific areas of interest. The CHA covered a broad list of health determinants to better understand community health.

The health assessment explored several areas of health, including the environment, lifestyle, socio-economic and genetic determinants of a participant. The survey questions consider the *physical environment* in which people live and the impact it plays on shaping future health outcomes. An individual's location can determine the amount of resources they have access to and the likelihood they will be utilized. In application of the CHA, the physical environment proved to be a veritable force. Much of the CHA is conducted in rural environments and in areas of western North Carolina not easily accessible by car. The health assessment survey explores questions concerning an individual's *social environment.* The level of social and emotional support people feel they receive from friends and family. There exist strong correlates between positive health behavior changes and social support systems. Another area of health we investigate is the existence of *poverty,* which has the potential to shorten and reduce the quality and enjoyment of an individual's life. Without subjective questions or surveyor's assumptions, we can infer upon the existence of poverty through questions about income. Another important area of consideration we assess in the survey is the impact of *lifestyle*. For example, as public health majors we recognize the connection between smoking and increased rates of lung cancer and coronary heart disease.

The health assessment identifies regions of Asheville where smoking is more prevalent and in turn can work to address this community. Health promoters are more inclined to target the area for anti-smoking campaigns, compared to a blanket campaign and no target audience. Lastly, there is an area of the survey that has perfunctory purpose and is concerned with *family genetics* and *individual biology.* As science continues to advance every day, we are learning more about the impact of our genetic disposition and the role and extent to which they shape health outcomes. In the book *Health Inequality: Introduction to Theories, Concepts, and Methods* Mel Bartley asserts, "Many studies in the past were based on the assumption that there are biological similarities among members of the same racial group (genetic homogeneity) and differences between groups that might give rise to differences in disease risk. This is very rarely true…these genes do not seem to be very important for the ways in which the body works or responds to disease hazards" (153). Although this area is not explored in depth in the Buncombe County CHA, we do ask a multitude of questions that are concerned with race and

ethnicity.

A strength of UNCA as an academic institution is that it provides opportunities for students to participate in civil service and community engagement prior to graduation. This simple requirement forces individuals to work with other populations and new communities that can serve as a catalyst for humility and compassion. Community involvement precipitates living mindfully because we come to understand the interconnectedness of all life. As I continue to work on my final Community Engaged Scholar project, I am thankful for the opportunity to witness and interact with different aspects of the community that are very often hidden from the public view. I receive insight into the struggles and pains of modern American families, the struggles that will likely never be seen on the nightly news or in any major weekly news publication. I interview individuals at the top of the socio-economic ladder and families that are suffering chronic poverty. Within Asheville, there is a diverse distribution of wealth and in turn a stratification of health. As health promoters, we are keenly aware of the link between social class and mortality rates. Mel Bartley reflects on the history of public health, stating:

> Health inequality was put firmly on the map of both public policy and academic study with the publication in the United Kingdom of the Black Report in 1980. This compilation of data on the relationship of ill health and mortality, in England and Wales between 1950s and the 1970s, showed that the prospects of death at most ages, and thereby of a long life, were strongly related to a measure of social and economic position referred to as 'social class.' In the British context, the term 'social class' created such a powerful popular image that then, and for many years afterwards, the relationship to health seemed to require little further explanation (1).

This same perspective holds true in modern social epidemiology, pointing to the socio-economic causes of illness and death. The goal of research is to hopefully influence the policy goals directed at ameliorating negative social impacts of health. The health assessment is part of a continuum of health promotion and care within a community. It identifies health inequities within the community and hopefully works to yield insight for the power structures that control the distribution of resources. While the unequal distribution of wealth remains one of the strongest determinants of mortality and morbidity, we are learning that health and wellness is achieved through a multitude of agents.

Working with the CHA I have witnessed a host of determinants in various communities and environmental settings. With much of my experience, I was invited into the homes of the residents and asked to stay for tea or coffee. Here I observed elements of the classroom manifested in real life situations. One particular family had experienced the unintentional negative side effects of urban renewal and de-segregation especially hard. The individual spoke about the impact desegregation had on black business and agriculture. Communities of color were forced to assimilate into the infrastructure of the white communities. This had a crippling impact on the black businesses of Asheville. Furthermore, the impact of urban renewal sent a shock wave through generations of black families after they were forced to relocate or disperse into various districts. Urban renewal, under the guise of 'community improvement', like Sarah H. Judson points out in *Crossroads* magazine, "Asheville was one of many cities across the United States that participated in urban renewal, part of a national effort during the 1950's through the

1970's to improve the so-called blighted areas…In practice, many rich and vibrant communities of color were flattened throughout the United States" (1). Having the opportunity to speak personally with residents who endured this tragic period gave me pause and reminded me that our history shapes the health outcomes of populations years later. There are socio-cultural determinants that took root half a century ago whose repercussions are only now being felt. Similarly, I would be driving through rural pockets or Enka/Candler and just arrive upon an entire farm, with acres upon acres of apple fields, with only a handful of Hispanic workers picking them. I had the opportunity to speak with one of the farmers. The results from this individual's survey mirror those larger health statistics of Hispanics in America. We have discussed the issue of Health Care in America in our classes, and particularly the study of Hispanic populations, rates of Healthcare, Healthcare literacy and a phenomenon knows as the 'Latino Paradox.'

According to the Pew Hispanic Center, in conjunction with the Robert Wood Johnson Foundation, they assert that eight in ten Hispanics report receiving health information from alternative sources, such as the television or radio. More than one-fourth of Hispanic adults in the United States lack a usual health care provider, and a similar proportion report having no health care information from medical personnel in the past year (Hispanics and Health Care). The paradox that is recognized in academia is that "Even after adjusting for their relative youth, Hispanic adults have a lower prevalence of many chronic conditions than the U.S. adult population as a whole" (Hispanics and Health Care). Non-native Hispanic populations that move to America experience, statistically, lower rates of health disorders compared to their American counterparts. Data reveals that the health of the Hispanic populations holds steady for the first few years, but as assimilation into American culture deepens, there is a corollary negative health gradient. This phenomenon highlights the negative health implications of our American society and culture. As health promoters, we are interested in how lifestyle, environment, socio-cultural and genetic agents contribute to various health outcomes. We can observe the impact of years worth of chronic stress on the body; the human body is yet to adapt physiologically to the demands of modernity. Stress releases the hormone cortizol into our blood stream which triggers the 'fight-or-flight response'. While this is an essential aspect of survival and even making it through our days, chronic stress and anxiety can lead to cortizol overload. The product of year's worth of stress is manifested in immeasurable amount of ways, including increased rates of pre-mature births, diabetes, high blood pressure/cholesterol and congestive heart failure.

It is our responsibility as health promoters to come up with creative ways of addressing these factors and promote healthy living. We learn in the Transtheoretical Behavior Phases of Change model that individuals must exist within the 'precontemplation' and 'contemplation' phases of behavior change before the seed is planted and true change can begin. During the 'preparation' phase, individuals are poised to take action and their intentions are equally aligned. The community health assessment helps instigate these early phases of behavior change. As health promoters, we also explore the work of personal wellness coaches (trainers). It is this inter-personal level of health promotion that focuses primarily on the 'action' and 'maintenance' areas of healthy behavior change. We are versed in the various layers of behavior change and understand the

importance of a social support net. The CHA has the potential to instigate positive health behavior change. The questions alone force individuals to reflect upon their diet and lifestyle and choose the appropriate level of self-satisfaction.

Challenges Faced and Responses to those Challenges

The Buncombe County Health Department identifies the community health assessment as the "foundation for improving and promoting the health of county residence" (BCHD). They recognize the community health assessment as a key in the continuous community health improvement process. The role of the CHA is to "identify factors that affect the health of a population and determine the availability of resources within the county to adequately address these factors" (BCHD). While working with Marian Arledge, she impressed upon me the significance of completing the community health assessment and producing the supplemental report. She expressed concern at the shortage of resources provided to conduct and finish the CHA/report in an appropriate amount of time. The greatest challenge, from the beginning, was completing the two block groups and writing a supplemental report. Completing the surveying was the priority, and it was also the most difficult. It was because of this specific need that I decided to make a commitment to the Health Department to continue working and help coordinate the CHA.

I decided to commit until the very end and see the project through. This decision has made all of the difference and shaped the future of my involvement with the CHA. One of the greatest challenges I faced was figuring out how to streamline the training session for students and provide more time and experience in the field. Throughout the summer of 2012, I worked along side UNC Chapel Hill graduate students at the Buncombe County Health Department to create and implement a program of education for the health assessment. We developed a compressed version of the Power Point presentation, produced paperwork that surveyors could carry with them as an on-site reference (protocol, Trimble manual, etc.) and created Google documents that could be accessed by multiple parties.

As we continued the training process, it gradually improved until it eventually became the easiest part of the whole CHA. The next barrier that presented itself was in regards to the organization and planning portion of the student training. It was nearly impossible to have all of the students' schedules coincide and find free time to conduct the CHA. This required making myself available to the students throughout the week. I was responsible for carrying all of the supplies (pens/pencils, reflective vests, resource cards, surveys, etc.), the Trimble, directions, surveys and gas cards. My truck became the ad hoc resting place for these items so I could easily coordinate a meeting at any time; I was able to meet the students at a specified drop-off point and then return several hours later to check them in. During the check-in process, we would review their day's work and answer any questions or concerns. I learned that I must become more flexible, adaptive and most important, make myself available (via cell phone) at all times. Reflecting on the most pressing challenges of the CHA, it is hard to avoid the reality that human errors and shortcomings, on my end, can balloon into bigger issues. Simple miscommunications carry greater weight and have the potential to impact a larger audience of people.

Something as simple as miscommunicating the number of printed maps available could result in an officer not patrolling closely with the student surveyors or addresses not being found. Two concerns took top priority during the final phase of the health assessment. The first complication was how the surveyors failed to properly identify the address of the house they finished surveying. The second issue is that they improperly entered the data into the Trimble and failed to save the hard-copy duplicate answers. These are two common issues that continue to appear, regardless of the skills or intentions of the surveyor. As a result, I created a document that outlined the proper steps to take in controlling the Trimble and also made sure I individually spoke with every student before they went out. Human error is a constant with the CHA, and we accept this reality. In turn, we must consider the houses that have neither the Trimble record nor the hard copy as houses that are 'yet to be surveyed' and consequently we will return to these addresses and repeat the survey. With every challenge encountered during the health assessment, I was forced to adapt and overcome because the only other option was quitting. There often existed no other choice. This is why it proved to be such a powerful experience. I was forced to grow and learn. I was subjected to uncomfortable situations and environments and ultimately had to choose which way I wanted to travel. In the end, I chose to continue working with the CHA and engaging new populations.

Results

As of the first of April 2013, the health assessment has officially completed surveying the 28715-block group of Enka/Candler and has 29 surveys remaining for the 28806, west Asheville region. We worked closely with the Health Department to monitor progress and maintain strict protocol throughout our mission. We hope that the results will highlight our dedication to structure and protocol. The official results will be presented within the final project report, a supplemental report of the findings alongside the regional report. The projected completion of this venture is slated for June of 2013. While the final report is going to be produced in the near future, there are several key factors that stand out as achievements. A major accomplishment for the CHA is the strong partnership that has developed between UNCA and the Buncombe County Health Department. Through the collective work of Dr. Batada at UNCA and Marian Arledge at the Health Department, students now have the opportunity to explore the field of public health and experience work that is happening at a community level. This is a relationship that benefits both partners. The Health Department is given extra resources to engage in various health promotions ventures, and the students receive first-hand experience in the field. This reflects the Mission and Student Learning Outcomes goals for the Health and Wellness department of UNC Asheville. Working with the health assessment is aligned with department goals including "the university's commitment to the development of critical thinking skills and communication skills as evidenced by clear and thoughtful exchange of ideas in and out of the classroom setting" (UNCA).

In addition, "the Department's dedication to cultivating an understanding of the human experience is substantiated through the creation of courses emphasizing knowledge and content in health parity, health and media literacy, diversity in gender and sexual expression, and differences in ability and courses that provide service learning activities

which involve people of diverse backgrounds" (UNCA). The experience of entering into new communities and engaging with them is a skill that reflects the university's dedication to creative community service and civic engagement. It is opportunities like this that generate growth within a student in ways not possible within the confines of a classroom. The University states, "This is done through service learning, student volunteer activities, training students to be advocates for social justice, and faculty participation in service activities individually and as an entire department" (UNCA). My experience with the CHA has resulted in fulfilling a myriad of academic objectives. Through a community health assessment, I am allowed to navigate various public health tools and methods for assessing community health. The process proves as valuable as the results. Striving to "develop skills to effectively motivate changes in health behavior, utilize health assessment tools and to plan, implement and evaluate health promotion programs among diverse populations and in various health promotion settings" is essential to the Wellness program of UNCA (unca.edu). Furthermore, this experience allowed me the opportunity to grow in the field of public speaking and oral and written health promotion presentations. In every environment, whether in the classroom training students, or in the community talking to a diverse range of individuals, I was training to think critically and communicate effectively. At the core of the community health assessment is a drive and purpose to the "quality of life and health for others" (UNCA).

Sustainability

Author Kevin Dew discusses the issue of sustainability in the public health arena as the connection between humans and their environment, "totalizing the scale of public health" (48). He asserts that historically the idea of sustainability has been presented in many forms. "Marx developed the theoretical concept of metabolic rift that drew attention to concerns about soil fertility in capitalist agriculture production, the pollution of cities, overpopulation and deforestation" (Dew 48). Considering the work of the CHA, sustainability is the ability of the CHA to be reproduced and replicated for future generations. This is why the WNC Healthy Impact initiative is so vital. It is a partnership working to promote sustainability and efficacy of future community health assessments. They identify six goals pertinent to our work with the CHA, including:

- Partnership. Enhance partnerships between hospitals and health departments in the community health improvement process.
- Local Leadership & Engagement. Continue and support local-level health assessment, planning, and related community engagement.
- Efficiency & Standardization. Standardize collection and reporting of health-related data for all 16 counties in the region.
- Regional Value & Synergy. Work together regionally to develop a collaborative process to efficiently and effectively assess and address health needs across the region.
- Accountability to the Community. Meet hospital and health department requirements for conducting community health (needs) assessments, action plans and implementation strategies.
- Strategic Investment. Better align community investments with the health priorities

identified through the community health assessment process (WNC Healthy Impact).

These are powerful factors that promote sustainability and foster community. Community is key to sustainability. Every member is held accountable with equally vested interest in his or her collective outcomes. We are moved via social capital (norms, values and ethics) to engage in positive and lasting enterprises. The CHA is the beginning of a continual process of growth and re-assessment. Health is not an end-point that we will ever arrive at but a continuum of care which will be built upon and which we can improve. The WNC Healthy Impact is tasked with informing the future planning, implementation and assessment of the western North Carolina CHA's. Furthermore, they are developing a toolkit that can be utilized during future CHA's to identify possible gaps and shortages in resources throughout the data collection process. Lastly, they are an organization of work group members dedicated to making the process more efficient and goal-oriented. They are also preparing a marketing strategy for the products that result from their collaborative project efforts. These efforts will minimize the responsibility of the Health Department to carry the CHA and instead separate the responsibilities to a larger audience of professionals. This will streamline the CHA process and benefit all parties involved.

Conclusion

A community health assessment is a fundamental resource in the continuum of health promotion for any population. The community health assessment experience provided insight into the disparities of health impacting a diverse range of individuals. The determinants of health are equally evident in the data collected from the CHA survey. While the health assessment serves the purpose of identifying the health inequalities that are present within the community, it also served as a personal catalyst to learn and explore the various ways health is manifested in different populations and the subsequent determinants of such outcomes. Health is a dynamic state and in turn this demands tools and people that are adaptive and prepared for a multitude of situations, working to find new and creative ways to address future health concerns. The CHA not only enhanced my academic experience and allowed for special insight and understanding of the power of health promotion but also emphasized the significance of civil service and community as we enter the next century. Through the training of surveyors, data collection and analysis of the results, I have come to understand the systemic determinants of health and how they generate stratified negative health outcomes. I have grown as a student and gained a new passion for social justice. I remain inspired at the possibilities for health promotion in addressing 'the mountain of health inequities.'

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