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Community-Based Health Interventions in an Institutional Context

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Steven L. Arxer • John W. Murphy
Editors

Community-Based Health Interventions in an Institutional Context

Editors
Steven L. Arxer
Department of Sociology and Psychology
University of North Texas at Dallas
Dallas, TX, USA

John W. Murphy
Department of Sociology
University of Miami
Coral Gables, FL, USA

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Contents

1 Introduction 1
John W. Murphy

2 A Community-Based Organization 11
John W. Murphy

3 Establishing Community-Based Primary Health Care 23
Karen A. Callaghan

4 Community-Based Funding and Budgeting: Participatory Budgeting as a Transformative Act 39
Jung Min Choi, John W. Murphy, Ramsey Dahab, and Charlene Holkenbrink-Monk

5 Aims of a Community-Based Research Program 53
Steven L. Arxer

6 Training Community-Based Health Workers 63
Tashina J. Vavuris

7 Creating a Community Health Worker Training Program 73
Dawn Graham, Kerri Shaw, and Lesli Johnson

8 Is the Affordable Care Act Encouraging Hospitals to Engage their Communities? Experiences from Appalachian Ohio 91
Berkeley Franz, Daniel Skinner, and Danielle Dukes

9 Community-Based Political Interventions 109
Karie Jo Peralta and Krista McCarthy Noviski

10 Re-examining the Role of Patients in Community-Based Interventions 125
Khary K. Rigg, Amanda Sharp, Kyaien O. Conner, and Kathleen A. Moore

11 Work as Health: Tensions of Imposing Work Requirements to Medicaid Patients in the United States 139
Elaine Hsieh and Eric Kramer

12 Overcoming Institutional Barriers Faced by Community-Based Healthcare Institutions 159
Airín D. Martínez

13 Conclusion: A Re-evaluation of Institutionalized Health Care 179
Steven L. Arxer

Index 185

Contributors

Steven L. Arxer is Associate Professor at the University of North Texas at Dallas in the Department of Sociology and Psychology. He has a PhD in sociology at the University of Florida. Arxer specializes in qualitative methods with a focus on minority populations, intersectionality, and gender. He is co-author of *Aging in a Second Language*.

Karen A. Callaghan earned a BA in sociology at La Salle University (Philadelphia) and MA and PhD in sociology at The Ohio State University. Callaghan's areas of interest include participatory community-based research, community organizing, and service-learning. Callaghan is currently Professor of Sociology and Dean, College of Arts & Sciences at Barry University, Miami Shores, Florida.

Jung Min Choi received his BA at UC Berkeley and finished his PhD at York University in Toronto, Canada. He is Associate Professor in the Department of Sociology at San Diego State University. He has published, all guided by anti-essentialist philosophies and community-based approaches, on critical pedagogy, race and racism, globalization and the bankruptcy of neoliberalism. He is currently President of The Dignified Learning Project, a nonprofit education-based organization in San Diego.

Kyaien O. Conner is Assistant Professor in the Department of Mental Health Law and Policy at the University of South Florida and a faculty affiliate of the Louis de la Parte Florida Mental Health Institute. She received her PhD, MSW, and MPH from the University of Pittsburgh and completed a postdoctoral fellowship in Geriatric Psychiatry at the Western Psychiatric Institute. Her research focuses on factors that influence disparities in mental health service utilization and treatment outcomes for African American older adults.

Ramsey Dahab holds various degrees in the Liberal Arts, including an MA in International Studies from Florida International University and a PhD in Sociology from the University of Miami. His areas of interest include nativism, global

inequalities, and social theory—the incorporation/development of pedagogies that help to fulfill potential in the world.

Danielle Dukes is a third year medical student at Ohio University's Heritage College of Osteopathic Medicine. She has research interests in the social determinants of health, food insecurity, women's and infant health, and mental health issues. She obtained an MS in Biology and an MBA with a focus on Health Care Management, from Wright State University before matriculation into medical school.

Berkeley Franz is a medical sociologist whose research and teaching focus on health disparities, hospital–community relationships, and health policy. She is currently Assistant Professor of Community-based Health at Ohio University's Heritage College of Osteopathic Medicine, in Athens, Ohio. She received an MA in religious studies from the University of Chicago and a PhD in sociology from the University of Miami. Berkeley has worked both domestically and internationally on community-based research projects and has published extensively on the theory and development of community-based partnerships.

Dawn Graham serves as faculty in the Department of Social Medicine at Ohio University Heritage College of Osteopathic Medicine. She earned a Doctorate in Counseling Psychology from Purdue University in 2010 and Master of Arts in Applied Behavioral Science from Valparaiso University in 1999. Clinical experience includes work in the University of Chicago Hospitals, Michigan City Area Schools, Purdue University, Porter Starke Community Mental Health, and Logansport State Psychiatric Hospital. Previously, she served as the Principal Investigator on a multi-million dollar federal grant to promote maternal/child health in Southeastern Ohio with university and community partnerships in coordination with the Ohio Department of Health. She is a member of the American Psychological Association and previously acted as Chair of the Ohio Psychological Association Public Sector Issues committee. Graham has been involved in multiple studies involving the impact of compassion fatigue for health care professionals working with underserved patients. She conducts national and international talks on health, psychology, and research.

Charlene Holkenbrink-Monk received her MA in sociology from San Diego State University and is currently enrolled in a joint doctoral program (San Diego State University and Claremont). Her research interests include community-based education and critical pedagogy. Currently, she teaches at California State University, San Marcos, San Diego Mesa College, and San Diego City College.

Elaine Hsieh has been involved in research on bilingual health communication for over a decade. She has conducted ethnographic studies, in-depth interviews, focus groups, surveys, and multi-phase studies that examine the interactions between providers and patients who do not share the same language. The three aspects that

she has investigated are: (a) the discrepancies between the beliefs and the practice of medical interpreters, (b) interpreters' influences on the quality of health care services, and (c) interpreters' mediation of conversational partners' identities and communicative goals. She also has received funding from the National Institutes of Health to further expand her Bilingual Health Communication model, exploring providers' expectations and needs for medical interpreters.

Lesli Johnson is Associate Professor. After a successful clinical career in mental health, Lesli joined Ohio University's Voinovich School of Leadership and Public Affairs in 1997 to lead the Planning, Evaluation, Education, and Research team, providing services to public and nonprofit organizations throughout the region and beyond. She has 20 years of experience working in community programs, including mental health, health, education, and child welfare. Dr. Johnson has been the lead evaluator on a number of state and federal efforts to improve health through community and integrated efforts. Areas of emphasis include promoting collaborative efforts, evaluating systems development, and engaging stakeholders in meaningful conversations and actions.

Eric Kramer has research interests that include mass media, international and intercultural communication. He is author of seven books including *Modern/Postmodern: Off the Beaten Path of Antimodernism*, *The Emerging Monoculture: Assimilation, and the "Model Minority"* and several journal articles and award winning papers. He has served on the review and editorial boards and has reviewed for several journals including *The Harvard International Journal of Press/Politics*, *The Journal of Communication*, *Communication Studies*, *The Journal of Applied Communication*, *The Journal of Intercultural Communication*, *Journal of International and Intercultural Communication*, *International Journal of Intercultural Relations*, *The Howard Journal of Communications*, and so forth.

Airín D. Martínez is Assistant Professor at the School of Public Health & Health Sciences at the University of Massachusetts—Amherst. Her research examines the sociopolitical and institutional arrangements that produce chronic disease disparities among Latinx immigrants and their US-born children. Her current research examines how the local implementation of immigration enforcement policies creates material deprivation and psychosocial stress among Latinx mixed-status families. She hopes her research can reverse policies excluding US immigrant populations and inform community-based prevention strategies.

Kathleen Moore is a research professor in the Department of Mental Health Law and Policy at the University of South Florida and Executive Director of the Louis de la Parte Florida Mental Health Institute. She received her MA and PhD in social/health psychology from Kent State University and completed a postdoctoral fellowship at Duke University Medical Center. For the past 20 years, she has worked on numerous community-based research projects with local addiction and mental health providers.

John W. Murphy has a PhD in sociology from Ohio State University. For the past 30 years he has been writing on and working in community-based projects in both the United States and several countries in Latin America. Most recently he worked on a health project on the Island of Grenada. Currently, he is Professor of Sociology at the University of Miami. Along with several of his colleagues, he is author of the book, *Narrative Medicine and Community-Based Health Care and Planning*.

Krista Mccarthy Noviski is a health coach and graduate student in the Department of Sociology and Anthropology at the University of Toledo in Toledo, Ohio. She received her BS in Pre-Medicine from Bowling Green State University in Bowling Green, Ohio and completed her health and wellness coach training through *Wellcoaches*. Her interests include social connection and health and the patient's experience of illness. Her current research is focused on empathy in medicine and the lived experience of teaching empathy to medical students.

Karie Jo Peralta is Assistant Professor in the Department of Sociology and Anthropology at the University of Toledo in Toledo, Ohio. She received her PhD from the University of Miami in Coral Gables, Florida. Her areas of interest are community-based research, third sector organizations, and applied sociology. Most recently, she worked in the Dominican Republic on a household survey of Haitian immigrant families and a growth assessment of their children.

Khary K. Rigg is Associate Professor in the Department of Mental Health Law and Policy at the University of South Florida and a faculty affiliate of the Louis de la Parte Florida Mental Health Institute. He received his PhD from the University of Miami and completed a postdoctoral fellowship in health services research from the University of Pennsylvania, Perelman School of Medicine. The overall goal of his research is to generate findings that improve the way drug prevention, treatment, and harm reduction interventions are developed and delivered.

Amanda Sharp is a PhD student in the College of Behavioral and Community Sciences at the University of South Florida. She received her BA from Humboldt State University and earned an MPH from Boston University. Her research focuses on how to make interventions more patient-centered through approaches such as motivational interviewing.

Kerri Shaw is the Social Work Field Director and the director of the Community Health Worker Training Program at Ohio University. She has been recognized as the 2014 Athens Foundation Woman of the Year for her work in the community, including the development of the Athens County Peanut Butter and Jelly Project. She earned both a bachelor's and master's degree in social work from Ohio University, is a Returned Peace Corps Volunteer, and is a fierce advocate and activist for women and children in Appalachia.

Daniel Skinner is Assistant Professor of Health Policy in the Department of Social Medicine at Ohio University, Heritage College of Osteopathic Medicine, on the Dublin, Ohio campus. He earned his PhD in political science from the City University of New York. The author of more than two dozen peer-reviewed academic articles in health policy, medical education, and political theory, Dr. Skinner is also co-editor of *Not Far from Me: Stories of Opioids and Ohio* (Ohio State University Press, 2019) and author of *Medical Necessity: Health Care Access and the Politics of Decision Making* (University of Minnesota Press, 2019).

Tashina J. Vavuris has a Master's in Sociology from San Diego State University where she explored educational inequities and community-based philosophy. Since then, she has been studying community-based practices and has collaborated in projects in Ecuador and Grenada centering on community health. Currently, she is a doctoral student at the University of California at Santa Cruz in the Environmental Studies Department, where she studies notions of sustainability, transformative pedagogical practices, and the process of community-based practices.

Chapter 1
Introduction

John W. Murphy

Community-based work is becoming quite popular nowadays. But since the passage of the Community Mental Health Act of 1963, health and other services were supposed to be attuned to the needs of communities (Lefkowitz, 2007). Local norms and definitions are important and should be consulted when planning interventions. This viewpoint was reinforced by the Alma-Alta conference in 1978 (Rifkin, 2009). As a result of this deliberation, local participation in service planning and delivery is deemed crucial for relevant and equitable health care.

Since Alma-Alta, two principles have come to characterize community-based projects (Murphy, 2014). The first is that local knowledge matters. The idea is that communities consist of reservoirs of knowledge that their members create and use as referents for judging health and illness, along with other elements of social life. Phenomenologists, for example, refer to these knowledge bases as "stocks of knowledge," while others refer to them as "worlds" (Schutz & Luckmann, 1973). In each case, the general theme is that persons define their situations, and that the accompanying values, beliefs, and commitments should guide the design, implementation, and evaluation of any program of action.

Community-based services should be built from the "ground-up" to enhance their relevance, due to the local nature of knowledge. To facilitate this strategy, the second principle of community-based work comes into play; that is, community members should control all projects. The goal of this change is to ensure that local customs and practices are not violated, and through their involvement communities are able to realize their skills and desires. Some critics refer to this outcome as empowerment (Geiger, 2016; Rappaport, 1984). But the practice is only logical: local persons understand the worlds that are operative and how they can be entered. Following this entrée, the assumption is that services or research will improve.

J. W. Murphy (✉)
Department of Sociology, University of Miami, Coral Gables, FL, USA
e-mail: j.murphy@miami.edu

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This shift in orientation represents a great advance. Not long ago local involvement was thought to be detrimental (Rifkin, 1996). After all, these persons are not professionals and thus lack essential skills. Recent research and practice, however, demonstrate that such claims are false. Local persons have exhibited skill levels thought to be beyond their station, and have been very helpful in dealing with health and related issues (Frank, 2010). Moreover, they have access to knowledge and social networks that are beyond the reach of outsiders, even those who are diligent and well-intentioned.

But a key element has been overlooked in those discussions of community-based work. Although community agency has been emphasized, the institutional framework of interventions has received scant attention. In other words, a key component has been ignored. That is, health and other interventions occur in institutional contexts that should receive attention. This conclusion is also consistent with the spirit of Alma-Alta. Despite this insight, the impact of community-based philosophy and practice on institutions is seldom mentioned. The purpose of this volume is to remedy this situation.

As might be suspected, emphasizing local participation changed the philosophy and configuration of service delivery. Practitioners, clients, and agencies, for example, are cast in a new light. Roles are changed and the usual organizational hierarchies are challenged. New sources of knowledge are exposed and consulted, while the nature of services and their delivery are rethought. For example, hospitals, research programs, training, and funding schemes are significantly altered. Nothing, in short, is unscathed by this shift to a community-based philosophy.

What Is an Institution?

Institutions have been conceived traditionally in realistic terms (Stark, 1963). Any organizations that have been institutionalized, therefore, have adhered to a particular formula designed to promote their legitimacy. Specifically, these organizations have been lifted above or removed from contingency. In other words, the illusion is created that they are divorced from partisan perspectives and thus provided with a unique, almost timeless status that reflects the common weal.

When portrayed in this way, institutions are bestowed with a "foundational" character (Fish, 1989). The point of this maneuver is to create a façade that can instill order and enlist loyalty. In fact, realists contend that order can be preserved only if institutions have a status superior to their inhabitants. As a result, these organizations appear to be normative and stable, beyond the political fray, and worthy of widespread recognition. Detached from any particular group or bias, institutions are presumed to have universal appeal.

To borrow from Herbert Marcuse, legitimate and lasting institutions have an "affirmative character" (Marcuse, 1969). Due to this status, they can impose durable customs and rules that stifle critique and thwart opposition. To make organizations seem substantial, and thus formidable, they are institutionalized through the use of

structural imagery. Serious organizations, for example, have a chain of command, a system of roles and statuses, and communication channels that reflect a particular logic. Given these descriptives, threats to the prevailing order can be controlled relatively easily.

Organizations that are institutionalized in this way have so-called binding power (Funk, 1998). That is, they can restrict choices and establish a sense of cohesion. Behavioral parameters can thus be imposed with little resistance, because of the power and prestige attributed to these organizations. As described by Erich Fromm (2005), everyone is diminished by these institutions; their legitimacy is simply undeniable and overwhelming.

Basically, a state of asymmetry is established between these institutions and almost everyone else. Those with power, and cultural or economic supremacy, can claim some association with these organizations and related privileges. But the remainder of persons are expected to be intimidated and readily conform to institutional requirements. In this regard, institutionalized organizations are transformed effectively into idols (Sung, 1989). What this designation means, in this context, is that they are not necessarily worshiped but that their imperatives are uniformly followed and seldom questioned. Institutions speak with unrivaled authority.

Such organizations, according to Karl Marx, would be treated as alienating (Marx, 1973). In other words, they have assumed a timeless and adversarial character that is unwarranted. Nonetheless, most persons are enthralled and dominated by their creations. The obvious question, however, is how does this distortion occur? How are persons led to believe that the products of their labor should control their lives? At this juncture, the simple answer is that through a subtle philosophy, institutions are granted the illusion of autonomy.

Institutionalization and Dualism

At first glance, community-based work appears to be mostly a practical undertaking. Organizing an intervention, indeed, demands that attention be directed to solving various technical problems. Likewise, learning to navigate institutions requires pragmatic awareness, a tolerance of tedium, and a willingness to compromise. Philosophy seldom comes to mind when considering these issues.

Nonetheless, at the core of institutionalization is a philosophical theme that is problematic. How do institutions achieve the appearance of autonomy? The answer to this question rests on Cartesianism, or dualism (Bordo, 1987; Leder, 1992). As noted earlier, once an organization is institutionalized, a specific arrangement of roles, jobs, and norms is superior to other forms of human organization. Put differently, people and their associations that stand outside of institutions are contingent and lack the presumed stability and obligations intrinsic to institutions. Cartesian philosophy enters at this point, as institutions are understood to be severed from their creators, given their unique structural status.

Cartesianism encourages the separation of subjectivity from objectivity. The rationale behind this separation is that subjectivity, based on interpretation, represents an unreliable source of knowledge. Through scientific methodology, for example, subjectivity can be overcome, thereby bringing objectivity into view. In this Cartesian picture, not only is subjectivity problematic, this source of information must be overcome for truth to be encountered.

Dualism allows particular information, or processes, to be severed from basic human expressions, such as choices, values, or interpretations. An organization that is institutionalized, accordingly, can be treated as autonomous, as if human agency is ancillary to the rules or hierarchies that are enforced. Through dualism, however, these organizations can become impediments to the ambitions of individuals or communities. In the language of sociologist Emile Durkheim (1983), institutions come to be viewed as existing "sui generis" and capable of providing constraints.

As should be noted, this version of institutionalization is antagonistic to community-based work. When predicated on realism, institutions are regularly insensitive to local demands, while community initiative is treated as a threat. When institutions are viewed as autonomous, local history and participation pose challenges to the *status quo* and are dismissed as uninformed distractions (MacDonald, 2016). Sound policy reflects institutional standards that are objective and rational, thereby minimizing community input. Community control, of course, is not part of the agenda.

But because community-based projects emphasize participation, particularly local knowledge and control, Cartesianism is revealed to be untenable. Neither knowledge nor organizations are autonomous because the standard location of these abstractions no longer exists. In community-based philosophy, dualism is undermined by the insight that individuals and communities create worlds of knowledge and that these domains can never be objective or timeless in the Cartesian sense. In short, their significance is always situated.

Institutions, therefore, must be approached differently in community-based work than in the past. Rather than autonomous, they should be viewed as narratives that simply inscribe a perspective on valid knowledge, order, and how health or any other issues should be conceptualized and addressed (Polkinghorne, 1988). As narratives, the Cartesian influence on institutionalization is rendered passé. Nonetheless, institutionalization and the related organizations do not vanish, but instead must be approached in a manner compatible with the anti-dualism prescribed by local participation.

Institutions and Community-Based Work

Community-based work subverts dualism by placing participation, or human agency, at the center of knowledge production and institutional life. As a result, organizations and their supports are removed from the pedestal reserved traditionally for institutions. In the absence of their usual autonomous status, institutions are

not prescriptions but possibilities linked to local practices. As some social philosophers might say, institutions are now local constructions (Gergen, 2009).

In the previous section, institutions were compared to narratives that serve to illustrate how social life might be ordered. Clearly, community-based work should thrive in this environment, since institutional control is transferred to local actors. But this recommendation depends on a particular thesis on language gaining recognition.

In terms of Cartesianism, language is envisioned to be a tool, particularly a pointer. The function of language, accordingly, is to highlight objects in the world, most notably their differences. Consistent with dualism, language does nothing but illustrate the traits of natural referents. The role of narratives, in this philosophy, is to describe the world in the most accurate way possible.

In a non-dualistic framework, on the other hand, language is not mimetic but creative. As Roland Barthes says, there is nothing outside of language that may emerge as objective (Barthes, 1977). There is no other option but to treat reality as a linguistic convention. Given the murkiness of language, narratives strive to bring clarity out of possible interpretations. Institutions, accordingly, stabilize a particular interpretation until further notice. Consequently, institutions are no longer ominous but subject to local control and (re)interpretation. The legacy of an organization, therefore, does not have to weigh heavily on an individual or community, but can be reinvented to meet local definitions and needs.

A hospital, neighborhood, clinic, or training center, for example, is expected to have a new identity and different relationship with clients. None of these institutions should be intrusive and obscure the worlds present in a community, but emerge from local interaction. Without support from dualism, organizations can return to being local constructions or stories, generated through discourse, that tell how a community defines health, the appropriate delivery of services, and acceptable outcomes (Charon, 2006). Such institutions are not obstacles but facilitate health care.

Organization of Book

This book examines as its central issue the impact that a community-based philosophy has on institutions and the institutionalization of community health delivery. Chapters in this volume explore how institutional arrangements can be rethought in ways conducive of a community-based approach. The volume considers how community partnerships, funding schemes, curriculum for health workers, the status of patients and clients, and community research programs, among other organizational features, are framed and designed from a community-based philosophy.

Chapter 2 addresses the broad question of what is a community-based organization. Here John W. Murphy explains how the focus of community-based work is local knowledge and community control of health projects. To deliver services in accordance with these principles, community-based organizations must be instituted. What these organizations require, separate from the past, is a different

management style and unique division of labor. Most organizations that are employed to provide health services in a community-based manner, however, have a traditional structure, and thus have difficulty fulfilling their aims. A new organization must be created that is consistent with the philosophy that underpins community-based work. Such an organization, for example, would be less hierarchical and not focused on a specific division of labor as in the past.

In Chap. 3, Karen A. Callaghan discusses how community-based partnerships are established within a new institutional framework. Community-based health services are not provided by stand-alone organizations. Simply put, a network of providers must be available. Accordingly, a variety of organizations must enter into partnerships. This arrangement is not necessarily novel, but traditionally these associations have been fraught with conflicts and struggles for power, thus undermining their effectiveness. Community-based partnerships, on the other hand, must be predicated on dialogue and mutual respect. Instead of fighting for dominance in a community, these new organizations must be integrated around the plans established by communities. A new way of conceptualizing and carrying out this process must be established.

Jung Min Choi, John W. Murphy, Ramsey Dahab, and Charlene Holkenbrink-Monk, in Chap. 4, explore the issue of funding and budgeting. Often funds are directed to community organizations in ways that are either irrelevant or difficult to use. Additionally, budgets are formulated by agencies that are disconnected from the communities where services are needed. Community-based funding and budgeting, accordingly, are beginning to receive serious attention. Communities, accordingly, are given the latitude in some cases to establish budgets and spending strategies, along with identifying and pursuing sources of funds that are consistent ethically with these priorities and desires. Community-based funding and budgeting, in this way, are vital to supporting interventions in a community-sensitive manner.

Clearly, research plays a key role in community-based health work. Understanding the health needs of a community is vital to the success of any health-care project. From an organizational perspective, however, the focus of a research program is often methodological. That is, developing scientifically sound data collection instruments is often the focus. However, such an emphasis leaves little room for appreciating how knowledge is socially produced and legitimized. Moreover, an overemphasis on methodological concerns can diminish the ability of researchers to appreciate the underlying assumptions of a community's worldview and frustrate their entrance to that world. Chapter 5, by Steven L. Arxer, examines the philosophical and practical considerations of implementing a research program in health projects that preserves the knowledge production of community members.

Chapter 6 focuses on the training of community-based health workers from a participatory organizational perspective. Tashina Vavuris argues that health practitioners receive a significant amount of training before and after they enter the field. But often, this education is mostly pragmatic, that is, focused on how to conduct needs assessments, evaluate interventions, or implement accreditation standards. Of course, these tasks are important. But this education does not necessarily begin with

the philosophy that sustains community-based work. When beginning with the principle that community knowledge matters, training must be initiated on how to enter the world constructed by a community's members. Every task, accordingly, must be thought of as a mode of engaging a community, instead of simply gathering data or making observations. Valid knowledge, communities, and norms, for example, must be rethought in the training process to produce persons who can work effectively in community-based interventions. This shift in orientation is not often the centerpiece of training.

Chapter 7 continues the discussion regarding health worker training, with Dawn Graham, Kerri A Shaw, and Leslie Johnson outlining key dimensions of developing a community-based curriculum for health worker training. The previous chapter explored the use of community-based health workers in interventions and the importance of integrating local experts into planning. In this chapter, they share the experience of developing a training curriculum for the State of Ohio. Given new rules regarding certification in different areas of the United States and internationally, developing a curriculum that can be approved and disseminated is of increasing importance. In these programs, significant institutional support is needed to develop curricula and train additional trainers, so that training can be shared with communities interested in integrating community health workers into their programming. The goal of this chapter is to present the challenges faced in creating a certified training curriculum and the potential for future curriculum development efforts.

Non-profit hospitals have the potential to be strong partners in community-based projects. Since the Affordable Care Act was passed in 2010, hospitals have new requirements to engage communities in identifying health needs and developing new community health programs. In Chap. 8, by Berkeley Franz, Daniel Skinner, and Danielle Dukes, a case study approach is used to explore how hospitals are developing new partnerships and the challenges they face in fostering relationships with the communities where they are located. Potential strategies will be suggested for improving communication between hospital employees and community members in the planning of community-based projects.

Karie Jo Peralta and Krista McCarthy Noviski investigate the political dimension of community-based organizations in Chap. 9. A central way institutions gain legitimacy and the ability to guide human behavior is through claims of value-neutrality and objectivity. Institutions are often thought to be bureaucratic and based on formal rules that facilitate decision-making in any sphere of life. In the case of health organizations, the language of science, technology, and standardization guide how community needs and the authority of health practitioners are understood. In this context, health professionals attain their unique status vis-à-vis patients and community members. But this dichotomy can contradict the aims of community-based health interventions. In particular, health organizations become the center of health assessments, while medical professionals attain greater power to direct health initiatives as opposed to patients. Nonetheless, community health workers, for example, require respect and legitimacy. In this chapter, the political dimension of community-based health organization is discussed, along with the challenges this model presents to conventional depictions of health institutions.

Chapter 10, by Khary K. Rigg, Amanda Sharp, Kyaien O. Conner, and Kathleen A. Moore, examines how the patient-provider relationship has evolved over the years. Patients are now thought to play a central role in the provision of treatment, especially within the context of community-based interventions. In both theory and practice, the role of the patient is supposed to differ from traditional biomedical approaches to treatment with patient input introducing a new level of transparency and relevance into service provision. Specifically, patients are to play an increasingly active role in health-care delivery and their backgrounds treated as central in any intervention. In short, a new form of participation between patient and provider is key to interventions that claim to be patient-centered and community-based. The current health-care system, however, does not promote such participation and obstacles to involving patients in their own care exist. The chapter traces the history of the patient-provider relationship and discusses the recent shift toward elevating the importance of persons receiving care. The authors also discuss obstacles to genuinely involving patients in their own treatment and make recommendations for how these barriers can be overcome. They conclude by discussing promising strategies for meaningfully involving patients in treatment, as well as how the role of patients in community-based care might be re-thought.

In Chap. 11, Elaine Hsieh and Eric Kramer focus on the health-care system, specifically highlighting the nature of debates about universal care. Of importance to the authors is not the arguments launched themselves but rather how polemics are being used to rationalize particular visions of health care. How communities are presented and imagined in relation to their work status, for example, is a central way in which arguments related to universal health care are forged and barriers erected. Hsieh and Kramer contend that a deeper examination of the philosophy behind current work-eligibility arguments to health care can promote dialogue on this hotly debated issue.

Airín D. Martínez continues the discussion regarding universal health care in Chap. 12. The focus is how a community-based health-care institution reimagines the basic operation of health care. Because a community-based model understands knowledge to be locally produced, the basic operations of identifying and exploring health needs changes, as well as the ways in which treatment is approached. Specifically, patients and communities do not internalize the directives of professionals, but rather collectively legitimize health initiatives and direct the process of community healing. Simply put, an entirely new model is proposed for identifying illness, formulating interventions, defining health, and evaluating outcomes.

The final chapter emphasizes the need for a re-evaluation of institutionalized health care. Drawing from the chapters described above, the benefits of institutionalizing community-based health projects is illustrated. To the extent that community-based efforts are described as substantially different from conventional health practices, health institutions must be conceptualized and operationalized anew to preserve the intentions of communities. Furthermore, an entirely new ethic of health care must be promoted. In short, a careful examination of how community-based projects can be institutionalized has the prospect for advancing effective strategies for community health planning.