ReThink Health®

A RIPPEL INITIATIVE

Hospital Systems in Transition

Community Influence on Nonprofit Hospital Systems

How constituents are organizing for more equitable nonprofit hospital systems

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Executive Summary

Healthcare systems and hospitals often feel caught between the business models that keep them afloat and the realities of what produces health and well-being—whether that is meaningful work and wealth, basic needs for health and safety, or other vital conditions a community needs to thrive. Through the *Hospital Systems in Transition project ReThink Health has embarked on a journey to explore what role* hospital systems could play in advancing well-being in their regions.

A growing number of people and organizations understand the need for action that is grounded in stewardship—action that enables all people to prosper and reach their full potential. We call these people and organizations "stewards."

Stewards are developing their abilities to:

- Take responsibility for forming working relationships with others to transform well-being across a region,
- Serve as natural boundary spanners because they are informed by place-based, interdisciplinary, multisector, and multicultural perspectives,
- Understand that purpose must be larger than oneself and one's organization, power must be built and distributed with others, and wealth must be invested to create long-term value as well as address short-term urgent needs.

To deeply understand the context and conditions necessary for hospitals to embrace system stewardship as a practice, our team decided to explore external drivers and forces that may influence hospitals leaders to shift their mindsets and actions towards advancing equitable health and well-being in their regions. For this paper, we are focusing on studying the influence of community organizing campaigns that are making claims on local non-profit hospitals.

This report is a deep study of these campaigns and initiatives. We believe that our field could benefit from studying examples around the country where leaders are organizing their communities to influence their local hospital systems. The examples of community organizing efforts focused on hospitals reveal the specific claims local constituencies are making on their local nonprofit hospital systems. Furthermore, as hospital leaders seek to negotiate equitable policies inside the walls of their institutions, hospital leaders can also benefit from a deeper understanding of the ways in which organizers are seeking to shift public opinion and influence hospitals from outside the walls of these institutions.

Furthermore, community organizers can learn about how fellow organizers from around the country are influencing local hospital systems, including which policy levers are being used as well as the limitations of those campaigns.

This paper does not represent the perspectives of ReThink Health. Rather, the paper describes what was observed about community organizing campaigns and the stated perceptions of organizers. ReThink Health does not endorse any of the specific claims community organizers are making on hospital systems but is simply noting what types of claims these organizers are making on hospital systems and the strategies they are using to influence hospitals.

Key findings

1. *Community leaders are primarily asking hospital systems to execute their existing roles more equitably as health care providers and employers, rather than asking them to address more peripheral social determinants of health, such as housing. Community leaders' goals potentially represent a misalignment with the SDoH focus that public health and think-tank organizations are advocating for hospitals to step into.*

2. *In certain cases, organizers influenced hospital systems to reallocate significant financial resources away from short-term profits towards longer-term value in the form of greater regional well-being. These include, among other cases, construction of a trauma center in a low-income African-American community, a cap on annual hospital price inflation and implementation of a living wage for hospital employees.*

3. *Organizers that successfully influenced hospital systems leveraged their abilities to mobilize public opinion, influence elected officials, and build diverse coalitions during key windows of opportunity (e.g., mergers acquisitions, hospital expansions, elections).*

4. *Organizers often faced limitations related to their ability to shape the hospital's internal structural and cultural factors. They also faced resource constraints that affected their ability to sustain their organizing activity beyond limited time-bound campaigns.*

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SECTION ONE

Introduction

ReThink Health believes that every community needs stewards. Stewards are people and organizations who take responsibility for transforming health and well-being across a region. Indeed, hospital system leaders can make a big difference in their communities if they step into a stewardship identity and orientation. ReThink Health is currently exploring the question of how hospitals can best claim an emerging role as regional stewards through the Hospital Systems in Transition Project.

However, community organizers are also critical stewards in their communities. Not only do they help communities make sense of emerging issues and mobilize communities to address those issues, but they are also able to hold institutions and leaders accountable. Professor Marshall Ganz defines a constituency as people who "stand together" on behalf of common concerns.[1]

This paper investigates instances where organized constituencies focused on helping hospital systems better exercise stewardship in their regions. A variety of research- and literature-based evidence has revealed that organized social movements throughout history have played crucial roles both in shaping public opinion, and in turn, influencing institutions (See Appendix 1).

How have community organizers influenced hospital systems to become better stewards?

In the past several years, there have been a number of attempts (some successful) in California, Connecticut, Florida, Illinois, New Jersey, and Pennsylvania to influence hospitals to better exercise stewardship in their communities, calling attention to their nonprofit status.[2] After all, communities care very much about their access to needed services. In addition, hospitals are often the largest providers of jobs in their community. In fact, this paper will show that, with a few exceptions, access to care and jobs are the only two things that people organize around.

Studying the activity, experiences, and perspectives of constituencies organizing to influence hospitals can reveal (1) what claims people are currently making on hospital systems, (2) how those claims are being crafted, and (3) what strategies and tactics constituents are using to successfully influence hospital systems. This paper illuminate's constituent perspectives, and in doing so, begins to answer the questions about how hospitals might think about the role of constituents in their work.

SECTION TWO

Methodology

This paper was developed based on 33 interviews with people who are a part of or who had conducted research on constituency organizing to influence hospital systems. They included: community and labor organizers, public health and public policy professors, and representatives from think tanks and nonprofits (See Appendix 2 for a complete list of interviewees). We supplemented the findings from these interviews with online research. We report the outcomes of these interviews in two places: In Section 3, we feature brief profiles of seven campaigns that influenced hospital systems, and in Section 4, we take deeper dives into three of these campaigns.

In the deeper dives, we share more information about local context, organizer perspectives, and hospital system responses.

The campaigns were led by the following organizations: Chinese Progressive Association (Boston, Massachusetts), Faith in Action (Aurora, Colorado; Camden, New Jersey; Kansas City, Missouri; and San Diego, California), Greater Boston Interfaith Organization* (Boston, Massachusetts), #HowardMedicine-Matters (Washington, D.C.), National United Health Workers (California), Pittsburgh United* (Pittsburgh, Pennsylvania), and Trauma Center Coalition* (Chicago).

Due to our heavy reliance on online sources, the campaigns discussed in this paper are primarily from large metropolitan areas with greater media coverage and statistical reporting. There are likely many more examples from around the country, and future research to ensure representation from rural and suburban hospital systems, as well as an increased number of metropolitan-based hospital systems, is recommended. ReThink Health welcomes anyone to share additional examples at ThinkWithUs@rethinkhealth.org.

We also acknowledge that the findings, which are largely reported results from interviews, are inherently biased as they represent only the perspectives of those interviewed.

* Featured as “deeper dives” in Section Four

SECTION THREE

Profiles of Constituent Organizing Focused on Hospitals

How do constituent organizers influence hospital systems?

Summary of Key Insights

- Constituent organizers influenced hospital systems to make significant financial commitments (sometimes in the hundreds of millions of dollars), including constructing a trauma center, capping insurer-negotiated price increases, and implementing a minimum-wage increase to $15 per hour.
- Organizing often occurred when constituents viewed hospital systems as committing harm or falling short in the provision of a fundamental service or obligation.
- Campaigns primarily focused on influencing hospital systems to be more equitable health care service providers, large employers, and developers (see Figure 1). They called on: providers to provide care that is affordable and accessible for all community members; employers to provide a living wage, ability to unionize, and adequate resources to care for patients; and developers to expand in ways that take the surrounding built environment into account as well as the potential for displacing residents (particularly communities of color and low-income communities).
- Organized constituencies included racial justice, faith, and labor entities, which often framed their campaigns as issues of racial and economic justice.
- Campaigns focused less on hospital systems' obligations to address social determinants of health (SDoH), even though SDoH can be a powerful concept for organizers focused on other institutions.
- Across the organizing landscape, many constituents are focused on influencing institutions other than hospital systems (e.g., national policy makers, local officials, pharmaceutical companies) to address their health care and SDoH issues.
- Constituent organizers often lack an understanding of the grounds on which constituencies might pressure hospitals, often due to a lack of understanding of which policy levers they can use to influence such complex institutions (Please see Appendix 3 for more details and examples)

FIGURE 1

Racial justice, faith, and labor organizers launched campaigns to push hospitals to be more equitable health care, employer, and developer institutions.

	Organization	What did they want?	Organizers wanted hospital systems to be equitable... Health Care Providers	Employers	Developers
Racial Justice	*Trauma Center Coalition*	University of Chicago (UChicago) to construct a trauma center in the South Side; UChicago to take responsibility for offsetting their expansion's gentrification impact	✓		✓
Racial Justice	*Chinese Progressive Association*	City of Boston to reject Tufts Medical Center expansion which would displace low-income Chinatown residents			✓
Racial Justice	*#HowardMedicine Matters*	Prevent George Washington University plan to build hospital which would decrease financial viability of neighboring historically Black University medical school	✓		
Faith	*Faith in Action*	Hospitals in four states to include patient voice to implement better care coordination for 'high utilizing' congregation members	✓		
Faith	*Greater Boston Interfaith*	Boston-area hospital systems to reign in hospital costs, driving up premiums for Bostonians	✓		
Workers	*Pittsburgh United*	University of Pittsburgh Medical Center to grant minimum-wage increase to $15/hour, right to unionize, health care access for low-income communities and communities of color	✓	✓	
Workers	*National United Health Workers*	Kaiser Permanente and State of California to increase mental health resources and pass mental health parity laws	✓	✓	

PROFILE 1
Racial Justice Organizers

Trauma Center Coalition identified a powerful strategic lever and galvanized support at multiple levels to influence construction of a trauma center in Chicago South Side.

Trauma Center Coalition

Organization background

- **Constituency:** Young residents from the South Side of Chicago (Fearless Leading the Youth) with the support of South Side faith community, university students and nurses
- **Motivation:** South Side is the most violent area of Chicago, but does not have a trauma center; beloved organizer was shot and died in route to trauma center on North Side

Campaign purpose and strategic objectives

- **Campaign Purpose:** Tackle racial health and health care disparities in the South Side of Chicago
- **Strategic Objectives**: Get the University of Chicago Medicine to construct a trauma center

Strategy and tactics used

- ***Strategy***: Jeopardize UChicago's ability to construct the Obama President Library and new cancer center by shaping public opinion and influencing notable black alumni and board members.
- ***Tactics***: Civil disobedience (chaining themselves to Office of Engagement, die-ins) at public events

Outcomes

- Achieved construction of the trauma center in 2018, as part of UChicago's $270 million construction of a new emergency department and cancer center
- Hospital established a community advisory council with two leaders from the Trauma Center Coalition
- Coalition now gearing up for campaign about UChicago's responsibility to stabilize displacement and gentrification caused by expansion

Sources: Sschorsch, Kristen, and Claire Bushey . 2016. "The Inside Story of Why U of C Medicine Changed Its Mind about a Trauma Center #Uofctrauma." Crain's Chicago Business. Crain's. April 11, 2016. https://www.chicagobusiness.com/static/section/trauma-power.html; Alex Goldenberg-Trauma Center Coalition, STOP, interview by Iueh Soh (author), April 9th, 2019; Amika Tendaji-Trauma Center Coalition, STOP, interview by Iueh Soh (author), March 11th, 2019.

PROFILE 2
Racial Justice Organizers

Boston's Chinese Progressive Association made an ethnic claim to land and used a referendum to reject the expansion of Tufts Medical Center into Chinatown.

Chinese Progressive Association

Organization background

- **Constituency:** Chinese-Americans (multi-generational and new immigrants) who live, work, play in Chinatown
- **Motivation:** Historically, Chinatowns provided support systems to weather racist legislation and racial terror—this was the only place Chinese people could live; gentrification now is displacing working-class residents from these supports and community

Campaign purpose and strategic objectives

- **Campaign Purpose:** Preserve land for working-class Chinese as well as support systems to allow Chinese immigrants to thrive
- **Strategic Objectives:** Protect Parcel C from being acquired by Tufts Medical Center

Strategy and tactics used

- ***Strategy***: Mobilize the Chinese American community to protest Boston Redevelopment Authority and push for a referendum to reject Tufts expansion
- ***Tactics***: Launch media campaigns, circulate petitions, partner with community-based organizers and health care advocacy organization (Health Care for All)

Outcomes

- Passed a referendum to reject expansion
- Tufts Medical Center now partnering with a Chinatown community task force to develop future expansion plans; future expansions loom

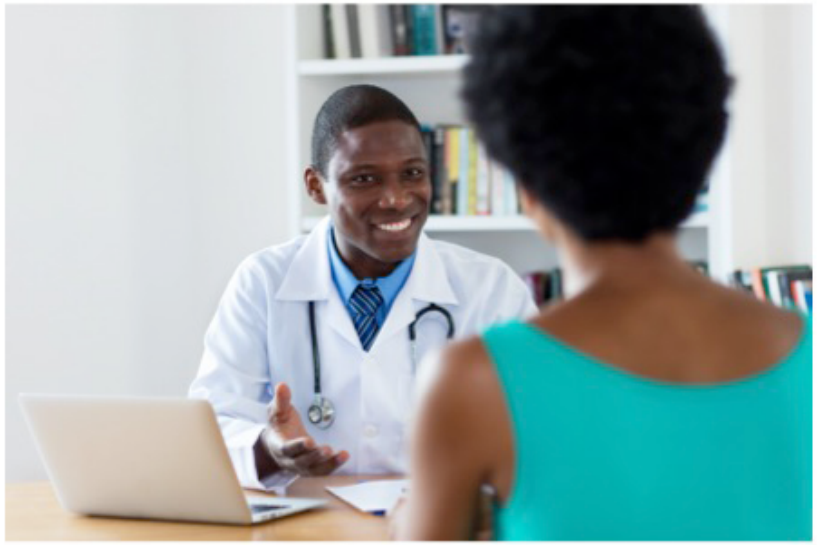
Sources: Vavra, Sharon. "Boston Chinatown's Gentrification Linked Historically to Tufts Medical Center's Expansion." The Tufts Daily. Tufts Daily, December 4, 2014. https://tuftsdaily.com/features/2014/12/03/boston-chinatowns-gentrification-linked-historically-tufts-medical-centers-expansion/.

PROFILE 3
Racial Justice Organizers

Howard University medical students have been fighting for the continued financial viability of their institution that trains Black physicians and serves low-income constituents.

#HowardMedicineMatters

Organization background	• **Constituency:** Howard University medical students, alumni, administrators as well as Black physicians • **Motivation:** The George Washington University's (GWU) new hospital would exclude Howard residents and decrease Howard's patient volume by 40% while reducing Howard's ability to serve low-income residents
Campaign purpose and strategic objectives	• **Campaign Purpose:** Protect the financial viability of Howard University Hospital and Medical School, which train the highest number of physicians of color in Washington, D.C. and serve a largely low-income, publicly insured patient population • **Strategic Objectives:** Amend the current GWU hospital proposal to include a partnership model that will grant access for Howard physicians



Strategy and tactics used

- ***Strategy***: Build support among D.C. residents, black community, and Howard community to pressure D.C. City Council and Mayor Bowser to amend the current proposal
- ***Tactics***: Social media, letter, and email campaign with alumni, faculty, staff, and students; packed attendance at a full day D.C. City Council meeting demanding they be heard

Outcomes

- D.C. City Council has been debating several options to amend the plan to include a GWU and Howard partnership

Sources: Airey, Julia. "Amendment Would Allow GWU, Howard University Partnership on New Hospital in Ward 8." The Washington Times. The Washington Times, December 4, 2018. https://www.washingtontimes.com/news/2018/dec/4/george-washington-university-howard-could-partner-/.

PROFILE 4
Faith Organizers

Faith in Action supported members who are high utilizers of health care to join patient councils and advise hospitals on how to better remove barriers to care.

Faith in Action

Organization background

- **Constituency:** Faith-based congregation members, schools, and others in communities with disproportionate number of 'high-utilizers' in Camden, NJ; San Diego, CA; Kansas City, MO; Aurora, CO
- **Motivation:** Patients in congregations experienced high emergency department (ED) and hospitalization rates; this was attributed to uncoordinated care, difficulty accessing transportation, and other barriers

Campaign purpose and strategic objectives

- **Campaign Purpose:** With grant from The Atlantic Philanthropies, empower consumers to voice their concerns to help shape their care delivery; develop leaders to be more proactive in their health and health care
- **Strategic Objectives:** Generate health care cost savings on high utilizers and return savings to Faith in Action to address SDoH

Strategy and tactics used

- ***Strategy***: Coach congregation members to join patient and family councils to provide testimony on barriers to reduce ED utilization and hospitalization rates; co-design an innovative care coordination and access model
- ***Tactics***: Organize high utilizer leaders to implement Faith in Action model of "research," and "actions"

Outcomes

- Program demonstrated cost savings, reduction in ED visits, and hospital admissions
- Patients sometimes reported challenges related to internal "hospital hierarchy and rigidity" and "health care language"
- However, initiative ceased when grant from The Atlantic Philanthropies ended

Sources: Sue Budd-ISAIAH Minnesota, interview by Iueh Soh (author), January 3rd, 2019; Meghan Carrier-Together Colorado, interview by Iueh Soh (author), February 8th, 2019.

PROFILE 5
Faith Organizers

Greater Boston Interfaith Organization (GBIO) built capacity by championing a health care cost watchdog entity and building from around State Attorney General Healey.

Greater Boston Interfaith Organization

Organization background

- **Constituency:** A collection of Boston-area church, synagogue, and mosque institutions spearheaded by GBIO's health care strategy team
- **Motivation:** Middle- and low-income faith community members faced declining real wages due to rising health care premiums

Campaign purpose and objectives

- **Campaign Purpose:** Ensure health care remains affordable in the midst of hospital system mergers, acquisitions, and expansions
- **Strategic Objectives**: Pass legislation to cap cost increases particularly for the Beth Israel-Lahey Health (BI-LH) merger, create a health care cost watchdog entity

Strategy and tactics used

- ***Strategy***: Pass a health care cost containment bill, establish the Health Policy Commission to trigger accountability processes and build support from Attorney General Healey to regulate the BI-LH merger
- ***Tactics***: Hosting state and local politicians at large public actions where over 1,000 + faith community members gathered to share their platforms and concerns

Outcomes

- Attorney General Healey announced an unprecedented seven-year price cap that would be implemented when BI-LH negotiates contracts with insurers, estimated to save consumers >$1 billion in forecasted cost increases
- In addition, BI-LH will contribute $72 million for lower-cost settings of health care and improved Medicaid access

Sources: Paul Hattis-Greater Boston Interfaith Organization, interview by Iueh Soh (author), December 3rd, 2018; Marcia Hams-Health Care for All (Formerly), interview by Iueh Soh (author), January 2nd, 2019; Bob Marra-Cambridge Health Alliance, interview by Iueh Soh (author), November 7th, 2018.

PROFILE 6
Worker Organizers

Pittsburgh United challenged University of Pittsburgh Medical Center (UPMC) to fulfill its obligation as a non profit and the largest employer

Pittsburgh United / Service Employees International Union Health Care Pennsylvania

Organization background	• **Constituency:** Coalition of labor unions as well as environmental, faith, and community groups • **Motivation:** UPMC, a nonprofit and the largest employer in Pittburgh, continues to expand without providing economic and health care benefits to existing low-income communities
Campaign purpose and strategic objectives	• **Campaign Purpose:** Ensure working families currently living in Pittsburgh can share in the prosperity of the new Pittsburgh 'Eds and Meds' economy • **Strategic Objectives:** Guarantee all residents equal access to health care, the right to unionization for workers, and a $15 per hour minimum wage in a community benefits agreement

Strategy and tactics used

- ***Strategy***: Put pressure on city council to negotiate community benefits as part of UPMC expansion, construct a public narrative of UPMC as a non profit bully, build coalitions with other service industry workers, replace city council with Pittsburgh United-backed candidates
- ***Tactics***: Striking (UPMC service workers), testifying at public hearings in city council chambers, writing op-eds

Outcomes

- City council voted to approve UPMC's expansion
- UPMC will contribute to address hunger, homelessness, and workforce development (none of which were Pittsburgh United's demands)

Sources: Jennifer Rafanan Kennedy-Pittsburgh United, interview by Iueh Soh (author), February 22nd, 2019; Silas Russell-SEIU Healthcare Pennsylvania, interview by Iueh Soh (author), February 22nd, 2019; Lisa Frank-SEIU Healthcare Pennsylvania, interview by Iueh Soh (author), February 22nd, 2019.

PROFILE 7
Worker Organizers

National United Healthcare Workers (NUHW) at Kaiser Permanente went on strike to protest insufficient mental health care and push for state wide mental health parity policy.

California Kaiser NUHW Mental Health Workers

Organization background

- **Constituency:** 4,000 Kaiser Permanente therapists, social workers, psychologists, support staff, dieticians, and health educators across the state of California
- **Motivation:** Frustration over long mental health patient wait times harming the ability of Kaiser Permanente workers to help their patients

Campaign purpose and strategic objectives

- **Campaign Purpose:** Improve access to mental health resources within Kaiser Permanente and statewide (mental health parity)
- **Strategic Objectives:** Increase reimbursement and staffing to reduce wait times for appointments, thereby reducing need to send patients to non-Kaiser Permanente therapists

Strategy and tactics used

- ***Strategy***: Increase visibility of issue across California and nationally by advocating for state bills and building patient support for movement
- ***Tactics***: Conducted five-day strike with protests outside Kaiser Permanente facilities in Oakland, Santa Rosa, and Santa Clara; held a forum on mental health parity with US Representative Joe Kennedy; partnered with patients to share their challenges getting access to mental health

Outcome: NUHW is currently in an open-ended strike

Sources: Dastagir, Alia E. 2018. "Will Your Therapist Go on Strike? 4,000 Mental Health Workers Protesting Kaiser Permanente." *USA Today*, December 7, 2018. https://www.usatoday.com/story/news/nation/2018/12/07/kaiser-permanente-strike-mental-health-workers-california-therapists/2225472002/.

SECTION FOUR

Deep-Dive Case Studies

A closer look: In what ways have organizers shaped the role hospital systems play in their communities? What is important about the context of these campaigns and the strategic choices organizers made?

CASE STUDY ONE

Trauma Care Coalition: Influencing the University of Chicago to Build a South Side Trauma Center

Key Insights from Chicago Trauma Care Coalition

- **Unique aspects of when and where:**
  - Southside Together Organizing for Power (STOP), one of the leaders of Trauma Care Coalition, is known to take on "impossible fights" rather than those that are winnable within three years; this campaign lasted over five years.
  - There has been a long-standing, contentious "'town vs. gown" relationship between University of Chicago Medicine (UChicago) and South Side residents.
  - The Black Lives Matter movement, after the police shooting of Laquan McDonald, served as a powerful backdrop to motivate and rally constituents.
- **Strategic decisions:**
  - Organizers found allies in key civil rights leaders and UChicago alumni that had the power to jeopardize the Obama Library project.
  - Organizers also built broad public support by staging direct actions during events, such as the unveiling of UChicago's $700M science center.
  - UChicago faith chaplains helped broker meetings between UChicago executives (after five years of refusing to meet with organizers).
- **Impact on shaping University of Chicago Medicine's role in the community:**
  - UChicago was able to find a way to meet both its health care delivery goals and the South Side community's goal to have a trauma center by creating the center as part of a new cancer institute.
  - Through their efforts, organizers believe they influenced UChicago to seek out new leadership for the trauma center that specifically shares the community's analysis of structural racism and inequity.
  - Organizers believe they influenced UChicago to look at violence (in addition to chronic diseases) as a public health issue. They have only had limited influence in shifting the hospital to utilize deep community engagement processes.

Sources "The Rumble & The Reversal." *Crain's Chicago Business*, April 11, 2016; Alex Goldenberg[3], discussion; Tinaja, discussion.[4]

CONTEXT

What is important about when and where the campaign happened? Three factors influenced the "when and where" on this campaign:

A history of town vs. gown relations. The community of Woodlawn borders the UChicago to the south and, for decades, has experienced adversarial "'town vs. gown" relations. That means the research institution and community members saw themselves as against each other.

In the 1960s, organizers Bishop Arthur Brazier and Reverend Leon Finney, Jr. (both trained by legendary organizer Saul Alinsky) helped organize the Woodlawn community to avoid being taken over by UChicago

They led the Woodlawn Organization, which became a national model, as they built a network of social programs and gained control of millions of dollars in publicly funded development. But despite this history, there were resurging questions about whether this anchor institution was doing enough for the residents of Woodlawn. Today, UChicago holds an endowment valued at $8.5 billion in 2019, while nearly three-quarters of Woodlawn residents are unemployed, and half of all families make less than $25,000 a year. It also ranks in the top one-third of zip codes for mortality rates related to gun-violence, kidney disease, and diabetes.[5]

Shifting racial dynamics. Organizers had already been calling attention to the lack of a trauma center in the South Side while millions were being poured into two UChicago construction projects: a cancer center, and the Obama Presidential Library. During the campaign, the saliency of racial injustice in the broader Chicago community began to shift after video was released of a Chicago police officer firing 16 bullets into teenager Laquan McDonald. Black Lives Matter and other activists decided not only to protest police shootings, but to call attention to the broader factors of community neglect, including lack of access to emergency care and recent closures of mental health clinics and neighborhood schools.

The loss of a beloved organizer. Damian Turner, a youth organizer for STOP (one of the lead organizations of the Trauma Care Coalition), was shot three blocks south of University of Chicago's medical campus—considered one of the best hospitals of the world. However, given that there was no trauma center, he had to drive to Northwestern Memorial Hospital, and many believe this drive contributed to his death. Claire Beverly, a journalist covering this campaign, reflected: "The young man was already an activist, organizer, and very well loved. A lot of his friends were organizers and were distraught. They were very upset."[6] Damian's mother even said that he had wanted to campaign for a trauma center after a friend was shot and killed.

THEORY OF CHANGE

What was the campaign strategy? What happened?

The purpose of the campaign was to tackle the institutional racism that resulted in poverty, segregation, and violence on the South Side of Chicago. The lack of a trauma center in the area of Chicago with the highest homicide rates and largest Black population was a visible representation of this. On the whole, the strategy was to dramatize the tension between a wealthy medical institution and its neighboring low-income Black community.

The campaign had a significant amount of non-financial resources: (1) networks and trust with a robust base anchored in the South Side community; (2) informal authority and relationships with ministers and local leaders as well as influential University of Chicago donors; and (3) access to strategic information. Most notably, the campaign had enough strategic information to realize that the most powerful levers would be to jeopardize UChicago's two most lucrative projects: the Obama Presidential Library (a project set to cost $500 million) and a cancer institute to compete with Northwestern and Rush Universities. "The campaign framing about how can the first Black president support a university denying Black life without a trauma center was the most effective," reflected Alex Goldenberg from STOP.[7] The campaign also knew UChicago, with $1.54 billion in revenue in 2015, had the resources for the trauma center.[8]

Tactics included civil disobedience at strategic moments, such as during a public tour of UChicago's new $700 million center for care and discovery. Veronica Morris-Moore, a crucial leader of the campaign, helped plan and conduct a sit-in at UChicago's Office of Civic Engagement, where firefighters had to hack a hole in the wall and arrest them. "Die-ins were a really creative and convincing way of making this argument, how could you ignore us when we are dying at your door?"[9] reflected Amika Tendaji, who worked with STOP and Fearless Leading the Youth on the campaign. Other tactics included building out a broader base of supportive constituents, including students, religious leaders, and representatives from other nonprofits to increase their strength and gain further public legitimacy. Lastly, the campaign gained the support of key opinion leaders among Black civil rights activists and UChicago alumni donors.

Reverend Dr. Michael Louis Pfleger, a prominent St. Sabina pastor, told university officials, including Susan Sher (Michelle Obama's former chief of staff), that he would organize to stop the building of the Obama Library unless a trauma center was opening too.

After more than five years, the organizers won the trauma center and, as of 2019, had two leaders on the newly created UChicago Medicine community advisory council. The council will advise the medical center on South Side health care priorities, including violence, cancer, sexually transmitted diseases, diabetes, asthma, and obesity. The coalition is looking to influence the hospital system to move upstream toward prevention and to staff its trauma center with "violence interrupters"—people who know communities personally and can help mitigate retaliation after victims arrive at the trauma center.[10] Most importantly, the organizers built relationships with one another under a broad coalition. The coalition—comprised of Southside Together Organizing for Power (STOP); Kenwood Oakland Community Organization (KOCO); the Jewish Council on Urban Affairs (JCUA); National Nurses United; Students for Health Equity (SHE), a university student group; and the Prayer and Action Collective (PAC)—continues fighting through the community advisory council for additional resources from the hospital system.

IMPACT

To what extent did organizers shift the role the hospital system played in the community?

The campaign seems to have made an impact specifically on the community benefits department of UChicago Medicine, which now sees violence as a public health issue (in addition to chronic diseases such as asthma, diabetes, etc.). However, there appear to be limitations on improving deeper and direct engagement processes with the community. Throughout the campaign and to this day, multiple organizers recall that UChicago administrators would have meetings to "feel them out," only to announce their decisions via a press release without meaningfully discussing them with organizers. "I believe part of it is a cultural thing, there may be some ignorance about the multiple hats community leaders can wear. We don't just do public actions, but we are capable of sitting down and strategizing in meetings," reflected STOP's Goldenberg.[11]

One huge win for the Trauma Center Coalition was that UChicago hired Selwyn Rogers as founding director of the Trauma Center. "He pretty much shares our analysis of structural racism, inequality, and what is needed to address it, and so he is a pole inside the institution. I believe our work made a difference because UChicago realized they weren't good on these issues and needed to bring somebody else in," reflected Goldenberg.[12]

In an interview with *Crain's Chicago Business*, UChicago Medicine leaders downplayed the role of organizing on the institution's decision to build a trauma center. "This isn't an issue that can be looked at in a silo," said Cristal Thomas, the community liaison for the hospital system. "We are engaged with our community, we assess their health needs, we listen to what they want and need from our hospital. We heard the voice of the trauma coalition; we heard the voices of many of our stakeholders."[13] They also denied that the Obama Library was related to their decision, but public records showed emails exchanged with Chicago Mayor Rahm Emanuel about this subject. Part of the complexity was that it was not clear from trauma researchers if another center was needed. For example, one analysis showed that Chicago had enough trauma centers, but perhaps in the wrong places.

Nonetheless, the campaign for a trauma center represented a fundamental challenge related to racial inequality and the "town vs. gown" fracture between the community and UChicago Medicine. Dr. Philip Verhoek, who works in the UChicago Intensive Care Unit, reflected on a similar situation in Philadelphia two decades ago where a trauma center helped heal a fractured relationship between the community and institution: "I'd love to see that be an outcome here, too...that this starts to mend the divide," he reflected.[14]

CASE STUDY TWO

Greater Boston Interfaith Organization[15]: Influencing Massachusetts Hospital Systems to Cap Their Health Care Prices Passed Down to Consumer Premiums

Key Insights from Greater Boston Interfaith Organization

- **Unique aspects of when and where:**
  - GBIO has robust civic capacity around health care organizing driven by the large numbers of congregation members employed in the health care sector, including some with deeper policy knowledge.
  - GBIO's health care team has major legitimacy, among both their broader base and legislators, due to the team's crucial role in helping to pass the 2006 state health reform bill as well as the 2012 state cost containment bill.
- **Strategic decisions:**
  - Through its championing of the Health Policy Commission, a health care cost watchdog organization, GBIO was able to support the creation of a government review mechanism, which found that mergers and acquisitions by Partners HealthCare and Beth Israel-Lahey Health (BI-LH) would likely increase costs to consumers.
  - GBIO not only established close ties with Attorney General (AG) Maura Healey, but also hosted her and other elected officials at public accountability actions (large gatherings of more than 1,000 GBIO delegates to try and get officials' commitment to specific actions).
- **Impact on shaping Massachusetts hospital systems' role in the community:**
  - In Massachusetts, hospital systems now must consider the impact of their mergers, acquisitions, and expansions have on increasing premiums and costs for Massachusetts residents.
  - Partners HealthCare has redirected its mergers and acquisitions strategy by seeking to acquire hospitals in Rhode Island and New Hampshire as well as plans to build a new tower at Massachusetts General Hospital (MGH), adding 200 beds, which could have similar impact on raising premiums.
  - BI-LH must cap its price increases that it negotiates with insurers for seven years. It also committed $72 million for lower-cost health care settings and to improve access (and marketing of its services) to the Medicaid population in its facilities, per AG mandate.

Sources: Hams, discussion[16]; Hattis, discussion[17]; Marra, discussion[18].

CONTEXT

What is important about when and where the campaign happened?

Two factors influenced the "when and where" on this campaign.

Boston context: Boston has a uniquely robust civil society focused on health care, including Health Care for All, GBIO, Community Catalyst, and other organizations. Many GBIO members are also health care professionals who work in the institutions of the CEOs they are pushing back against. Thus, they recognize the complexities and nuances of the issue. Relationships between 10 or so key leaders from these organizations has allowed these groups to coalesce around different issues over the years.

GBIO's legitimacy in health care: GBIO and Health Care for All collected more than 150,000 signatures to pass Massachusetts Health Reform in 2006, a law aimed at providing universal health insurance. The law contained an individual mandate, free and subsidized health care insurance for lower-income residents, and an employer mandate for employers with 10 or more full-time employees. After the passage, GBIO organized house meetings amongst their constituents to determine what a reasonable contribution would be for the connector care subsidies (Massachusetts plans for people that are at 300% of the federal poverty level or lower) and had a significant impact on the subsidy schedule. Policy makers saw GBIO as a legitimate source of information for these complex issues, and GBIO realized that it needed to use this influence to get beyond accessibility and start working on affordability.

THEORY OF CHANGE

What was the campaign strategy? What happened?

GBIO has become an influential health care organizing entity, having built up capacity by mobilizing its constituents, helping establish the Health Policy Commission, and building a strong relationship with the state legislature and the attorney general.

2011-2013 Health Care Cost Containment Bill

The "Capping Prices" campaign kicked off in 2011 when GBIO and Health Care for All launched a rally to freeze premiums at the Massachusetts State House. That year, GBIO also pushed its own members to do more to curb medical costs by rolling out programs in its members' mosques, synagogues, and churches to teach health literacy, encourage exercise, and promote end-of-life planning, among other things.[19]

GBIO brought a committed constituent voice to this complex public policy process.[20] It also partnered with the employer community to make Massachusetts the first state to set spending goals. GBIO proposed, with support from Associated Industries of Massachusetts (AIM), that health care costs should be capped at two percentage points less than the increase in gross state product. Ultimately, the bill was passed and capped price growth in line with the growth of the state's economy for the first five years, then a rate of 0.5% below economic growth. This was a compromise that came from AIM's and GBIO's advocacy efforts.[21] "No other state has tried to tie health care costs to the overall growth of the state economy," said Massachusetts Association of Health Plans President Lora Pellegrini.

This health care cost containment legislation also established the Health Policy Commission (HPC) to monitor cost trends and review health care mergers that could drive up expenses. GBIO had pushed for a mechanism to have this type of "truth telling" agency that could affect public opinion, provide facts to the attorney general, and make comments at Public Health Council meetings. Martha Coakley, who was attorney general at the time, asked GBIO Lay Leader Paul Hattis to serve as the consumer advocate commissioner. "It was a big moment," said Hattis. "GBIO saw that it as having a seat and having a representative to report back to GBIO."

2013-2015 Partners HealthCare Acquisition Accountability

GBIO did not launch a full-fledged campaign, but did call for public accountability of the South Shore Hospital acquisition by Partners HealthCare when the HPC determined that Partners HealthCare's acquisition of the South Shore Hospital would increase medical costs in the state by $53 million annually, GBIO did not launch a full full-fledged campaign, but did call for public accountability."[22] Attorney General Coakley had already come to a deal with Partners, but HPC's call for public review eventually led to a judge striking down the sale. Partners backed off the deal, but eventually bought the physician group (rather than the facilities) that was also part of the proposed transaction. This was not a win for GBIO because Partners could now receive the referral patient volume to their own more expensive facilities without purchasing new facilities, contributing to price increases like those they had hoped to avoid over the long run.

2017-2018 Beth Israel Lahey Health (BI-LH) Merger Accountability

In order to compete with Partners HealthCare, Beth Israel Deaconess Medical Center and Lahey Health, which owned and operated 13 hospitals between them, announced plans to merge into a single hospital system in 2017. When HPC determined that the merger could drive up costs by as much as $230 million dollars, GBIO called on AG Healey and other state agencies to protect consumers from this cost increase.

GBIO, at first, tried to create a "ten taxpayer group," which can form when there is a new building and/or new equipment being considered based on a certificate of need process from the Department of Public Health. However, GBIO found this group to have limited impact as it was only able to file commentary in the beginning of the process rather than work to influence the process throughout. GBIO shifted its strategy to working closely with the AG on drafting conditions if the merger went through.

Specifically, 1,400 GBIO members representing 43 GBIO institutions engaged AG Healey on this issue. At the event, GBIO issued an opening prayer and call to action. Rev. Canfield prayed, "Grant her [AG Healey] wisdom, courage, and strength… and connect her heart to those who manage households and pay the bills. God, when she steps into that negotiating room, give her a sacred stiff resolve of the people's attorney." AG Healey responded to GBIO's proposals by making several commitments in GBIO's call to action: "BI-LH needs to make a meaningful commitment to strengthen access for low-income communities and communities of color. I understand where GBIO is coming from, these are worthy arguments and critique you offered," she said. "I want to thank you for making this transaction a priority, your advocacy is making a difference."[23]

IMPACT

To what extent did organizers shift the role the hospital system played in the community?

In Massachusetts, hospital systems now must consider the impact of their mergers, acquisitions, and expansions on premiums and costs for Massachusetts residents.

One response from Partners HealthCare has been to shift its strategies to nearby states with more favorable market contexts. After AG Healey opposed Partners' purchase of South Shore Hospital, Partners shifted its growth strategy to focus on out-of-state growth. Partners has looked to grow acute care hospital ownership in New Hampshire through the purchase of Wentworth-Douglass and Exeter Hospitals. Partners is now trying to grow Boston's Brigham and Women's Hospital via purchase of Care New England in Rhode Island. Partners is also looking to expand via bed-expansion rather than the more regulated acquisition. MGH recently announced a two-tower project to add 200 beds on its campus. In some ways, bed expansions are worse than acquisitions because they shift patients away from lower-priced hospitals (potentially driving them out of business) and toward higher-cost care.[24]

The Health Policy Commission and AG Healey were able to set a new precedent for state agencies to play a more vigilant role in regulating hospital systems and their impact on health care costs. On Nov. 29, 2018, Healey announced an unprecedented seven-year price cap that would be implemented when BI-LH negotiates contracts with insurers. In addition, other demands of GBIO, such as BI-LH setting aside $72 million to fund lower-cost health care settings and improve access for Medicaid patients, were included in the agreement (See Figure 2 for more detail). "We were very pleased, the AG attempted to address almost every area of concern that we were advocating for," reflected Hattis.[25]

FIGURE 2

AG Healey's conditions for Beth Israel Lahey Health Merger

The unprecedented conditions will have a significant positive impact on the personal finances and health care access of low-income residents and communities of color

1

Abide by seven-year price caps

- Ensure price increases remain below state's annual cost growth benchmark of 3.1 percent for seven years
- Prevent $1 billion of potential cost increases projected by HPC from being passed down to consumer premiums and municipal budgets

2

Greater participation in treating MassHealth (Medicaid and CHIP) patients

- Enroll all licensed providers in MassHealth within three years; no caps on MassHealth patients served
- Implement a new advertising program to increase MassHealth patients in the hospital system

3

Set aside $72 million to support low-income communities and communities of color

- $50 million to community health centers and safety-net hospitals
- $17 million to mental health and substance use disorder treatment
- $5 million to boost access for communities of color and low-income communities

Sources: Kacik, Alex. "Beth Israel-Lahey Health Merger Clears Final Approval with Conditions." Modern Healthcare, November 29, 2018. https://www.modernhealthcare.com/article/20181129/NEWS/181129916/beth-israel-lahey-health-merger-clears-final-approval-with-conditions.

CASE STUDY THREE

Pittsburgh United and Service Employees International Union Healthcare Pennsylvania (SEIU HCPA): Influencing University of Pittsburgh Medicine to Improve Worker's Rights and Health Care Access for Low-Income and Senior Residents

Key Insights from Pittsburgh United and SEIU HCPA

- **Unique aspects of when and where:**
  - Pittsburgh has a strong union history from the city's steel-worker era.
  - University of Pittsburgh Medical Center (UPMC) garners broad negative public opinion, which appears to come most intensely from low-wage UPMC employees and Highmark-insured[26] seniors, who are being cut out of access to UPMC services.
- **Strategic decisions:**
  - Pittsburgh United/SEIU HCPA engaged in worker organizing, focusing on workers as members in communities who care about a broad range of health and health care issues in addition to labor; this allowed them to build a strong coalition of labor-, faith-, and environment-focused stakeholders.
  - Pittsburgh United influenced public opinion by crafting a narrative around the obligations UPMC, as a nonprofit entity, had to the community.
  - Pittsburgh United called on the state Attorney General and local officials to set conditions for its consent to UPMC's expansion to uptown.
- **Impact on shaping UPMC's role in the community:**
  - UPMC plans to raise the minimum wage to $15 per hour, which will shift wages among other employers as well (Allegheny Health has already followed suit and raised to $15 per hour); however, UPMC still holds anti-union policies.
  - Despite rejecting Pittsburgh United's proposed community benefits demands focused on access for lower-income patients and improved workers' rights, UPMC leaders and a city council member created their own community benefits agreement to address hunger, homelessness, workforce development, and events for businesses.

Sources: Ramanan Kennedy, discussion;[27] Frank, discussion; [28] Russell, discussion.[29]

CONTEXT

What is important about when and where the campaign happened?

The steel industry left a strong union legacy and culture among Pittsburgh residents that provided a foundation for health care worker organizing activity. In addition, UPMC is both the largest employer and the largest health care provider in the area. Thus, it disproportionately affects the overall wages in the community (its service wages dictate wages of other industries). Furthermore, UPMC's decision to leave the Highmark insurance network (Medicare Advantage plan) angered thousands of seniors who could no longer receive health care at UPMC.

THEORY OF CHANGE

What was the campaign strategy? What happened?

Pittsburgh United's theory of change was rooted in mobilizing residents over the long term in order to influence: 1) The perception and reputation of UPMC in the hopes of causing it to shift its policies and behaviors; and 2) Elections of local and state officials who would take an interest in regulating UPMC's behavior.

Pittsburgh United (which includes SEIU HCPA) engaged in what well-known organizer Jane McAlevey termed "full-worker organizing," focusing on workers as members of the community who care about a variety of issues, such as environmental justice, affordable housing, racial justice, and access to health care. The results were that many workers rights and health care access demonstrations were also attended by teachers, grocery workers, people from Pennsylvania Interfaith Impact Network, Pittsburgh City Council members, other local politicians, University of Pittsburgh students, and more. Myra Kazanjian, 66, a retired pastor who lives in Bethel Park, said, "It's actually sinful, the minimum wage in Pennsylvania."[30] Other protestors even framed the UPMC-focused campaigns as a racial justice issue, bringing Black Lives Matter signs to rallies. "Most Black people in Pittsburgh are service employees, and UPMC is the state's biggest employer," said Josh Malloy at UPMC Mercy.[31]

Fight for $15 per hour minimum wage and the right to unionize

One of Pittsburgh United's most tangible campaign outcomes was successfully pushing UPMC to raise its minimum hourly wage to $15. As expected, after UPMC raised wages to $15 per hour, Allegheny Health Network (a Highmark hospital), raised minimum wages to $15 per hour as well. "UPMC executives said they would never pay workers $15 an hour, but hospital workers came together to stand up for our rights and for better pay, and we won the raises our families and communities need and deserve," said Leslie Poston, a medical secretary who was earning $13 an hour. In addition to Pittsburgh United, different stakeholders claimed some of the success from this effort. Pittsburgh City Councilman Ricky Burgess, who last year chaired a hospital wage review committee, stated: "We believe that testimony before that committee helped change the climate and make this possible." John Galley, chief human resources (HR) officer at UPMC, reflected: "Because we're such a large employer, we had to do this in a way that wasn't going to be inflationary in terms of health care costs. HR worked to study the market, to do the forecast, to develop, and price the plan."[32]

Health care access for Highmark-insured patients

In addition to fighting for higher wages, Pittsburgh United has also demanded that UPMC be held accountable regarding the denial of access for seniors with Highmark Advantage insurance. Pennsylvania Attorney General Josh Shapiro responded to these protests and wrote a 2014 consent decree that required UPMC to accept Highmark and any other out-of-network patient for five years. "The consent decree modifications would do three things: first, require UPMC and Highmark to work together; second, ensure fairness for Pennsylvania taxpayers; and third, protect access for all patients," Shapiro said.[33] Lisa Frank reflected that pushing the attorney general and local leaders, city council, and the mayor to campaign on this promise to fix this lack of access led to the decree. "These would be totally unprecedented outcomes absent a coalition demanding that UPMC do this and making elected officials campaign to say they would do something to hold UPMC accountable,"[34] said Frank.

However, on June 30th, 2019, this consent decree ended, resulting in 175,000 Highmark Medicare Advantage plan members in Pittsburgh and Erie to lose in-network access. AG Shapiro pushed to extend this deadline, but a judge declined.

Community benefits agreement with UPMC's uptown expansion

In 2019, UPMC Mercy made plans to expand in Uptown Pittsburgh with a $400 million project as part of a larger $2 billion investment that includes a specialty cancer center and heart and transplant center in Oakland. This after UPMC acquired Mercy Hospital, which has traditionally been a faith-based hospital focused on charity care for the medically needy. Pittsburgh United has perceived these moves by UPMC as part of a plan to shift Mercy's image of a provider of community care to a health care destination for the world's elite. Jennifer Rafanan Kennedy, executive director of Pittsburgh United, reflected that the choice to focus on macular degeneration— more likely an issue for "wealthy, white, and well-to-do"[35] patients—as opposed to chronic diseases, such as diabetes and other needs identified by the Community Health Needs Assessment, provided the context for community outrage. Pittsburgh United attempted to aggregate testimonies from patients, mothers, and Black residents on their health needs. Notably, they did not have a well-established physician to lend them additional credibility.

During the expansion, UPMC needed to get zoning approved from the city council to allow for more aggregate accumulation of parcels. Pittsburgh United rallied over 100 of members to show up, testify, and pack the public hearing. They demanded that the city council only approve UPMC's expansion if UPMC also included a community benefits agreement. Pittsburgh United's proposed community benefits agreement would ask for improvement in wages,[36] the ability of workers to unionize, and expanded care for lower-income Pittsburgh residents. Many of the city council members initially agreed, but when it came time to vote for making the community benefit agreement a requirement, Pittsburgh United was not successful (in a 2-to-7 city council vote).

IMPACT

To what extent did organizers shift the role the hospital system played in the community?

The impacts of the effort fall into two categories.

1. *UPMC created its own agreement to address the community's SDoH, but did not want to address Pittsburgh United's claims for better health care access for low-income communities and workers' rights*.

   UPMC and the city council struck down the idea of requiring Pittsburgh United's desired community benefit agreement as illegal. However, Silas Russell of SEIU HCPA, reflected that the strangest result was that "the city council and UPMC still felt attached to the idea that there needed to be a community benefits agreement."[37] Thus, UPMC declared it would support the "One PGH" initiative. The initiative asks some nonprofits and organizations to give money towards hunger, homelessness and workforce development in Pittsburgh.[38]

   Pittsburgh United continues to push. Jennifer Rafanan-Kennedy responded that these did not reflect the needs stated by the community, saying in a statement that Pittsburgh United's "demands include access to UPMC hospitals for every resident who subsidizes them, accountability to reducing shocking health inequality in our city, living wages, and an end to union-busting in UPMC facilities… Make no mistake, the community did not make this agreement."[39] One interpretation of these events suggests that Pittsburgh United influenced UPMC and the city council to believe that something needed to be done for the community (a community benefits agreement was not previously on the table), but that their claims were too disruptive or radical for UPMC.

2. *Despite success on raising the minimum wage, Pittsburgh United believes UPMC leadership has remained closed to their constituents' needs and continues to focus purely on their profits.*

   Pittsburgh United did not have access to allies within UPMC leadership, especially after UPMC cut its board membership in half in 2011 when it announced its split from Highmark. This drastically reduced the type of information Pittsburgh United could get about UPMC's plans, including its motivations and rationales. Given UPMC's business activity and public filings, Pittsburgh United had access to acquisition targets and strategic plans, but did not have deeper communication and understanding.

   Raphanin-Kennedy reflected, "I continue to be surprised by how much profits drive their decisions… it's not as if they are Boeing, where they have shareholders."[40] However, Pittsburgh United still has an agenda to influence UPMC to be what it sees as more aligned with Pennsylvania's strong charity laws and to play a more profound role for the community.

SECTION FIVE

Key Takeaways and Implications

Assuming constituent organizing can help hospitals become better stewards of health and health care in their communities, what are the strengths and limitations of current organizing efforts?

Strengths and Limitations of Profiled Organizing Efforts to Shape Hospital Systems

Strengths

1. *Organizing goals, bringing constituents' priorities about addressing SDoH into the conversation.* Organizing goals are tied to the lived experiences of constituents and their current understanding of hospital systems, which may be different from the goals advocated by think tanks and foundations. Think tanks and foundations—often serving as "health ecosystem strategists"—are increasingly pushing hospital systems to address SDoH (e.g., investing in housing, transportation, etc.) outside the walls of the hospitals to advance well-being and equity in the community. Based on the national scan of organizing campaigns across the country, it seems that organizers are largely focused on influencing hospitals to hold themselves accountable to their core health care and employer mandates by ensuring that they not only prioritize SDoH, but the SDoH the community finds the most important.

2. *Organizing efforts shift accountability dynamics between hospital systems and constituencies.* Hospital system leaders are typically focused on their crucial and core accountabilities to insurance companies, physicians, and research departments. Successful organizing campaigns have been able to generate mechanisms to help hospital systems also recognize their accountability to constituencies such as residents, workers, and patients. For example, GBIO championed the creation of the Health Policy Commission, a health care costs watchdog organization with access to the Attorney General. Through GBIO representation on HPC, members were able to trigger cost accountability processes whenever Massachusetts hospital systems announced mergers, acquisitions, or the construction of new facilities. Also, the Trauma Center Coalition was able to establish UChicago's new community advisory council, which will seek to hold UChicago accountable to future community partnerships with the South Side.

3. *Organizing efforts take advantage of pivotal opportunities in which they have leverage.* Successful campaigns targeted key windows of opportunity when hospital systems required consent from state or public actors for mergers and acquisitions, footprint expansions, and new university projects (e.g., Obama Presidential Library). The Chinese Progressive Association, Pittsburgh United, and Howard University Medical School campaigns all recognized the need for hospital systems to gain consent from city council members to build a new facility. GBIO worked with the state attorney general to extract community benefits and limit price increases from the BI-LH merger. The Trauma Center Coalition built support from key community members that jeopardized the $500 million Obama Library for UChicago. Because organizers can exert pressure on leaders with formal or informal authority, they have the power to disrupt core business initiatives with significant financial consequences. Thus, they can get these issues on the agenda of senior leaders.

4. *Organizing efforts can mobilize public opinion.* In addition to being able to exert pressure on specific stakeholders, organizers are also able to shape public opinion in their communities. For example, by packing a public hearing discussing UPMC's community benefits agreement, Pittsburgh United was able to generate significant media coverage through numerous *Pittsburgh Post-Gazette* articles and social media posts (on Twitter, Facebook, etc.). "After that meeting, so many people in Pittsburgh were angry at UPMC and the city council that we could really channel it to unseat a number of those city councilors." reflected Lisa Frank from SEIU HCPA.

Limitations

1. *Organizing efforts have been unable to shift structural and cultural factors shaping hospital systems.*
   Organizers had success with shaping the specific actions and policies of hospital systems (e.g., getting a new trauma center, $15 per hour minimum wage, price caps), but less success shaping structural and cultural factors influencing hospital systems' ongoing decisions and operations, such as how care is reimbursed; who is sitting on the boards; and hospital leaderships' norms, values, and beliefs (See Figure 3). As a result, organizers could not tell if their efforts had helped influence hospital systems to build new types of capacity and instill a different commitment to health equity. Furthermore, most organizers did not focus on shifting the context or financial and regulatory incentives governing hospital system behavior. They say there are two reasons why.

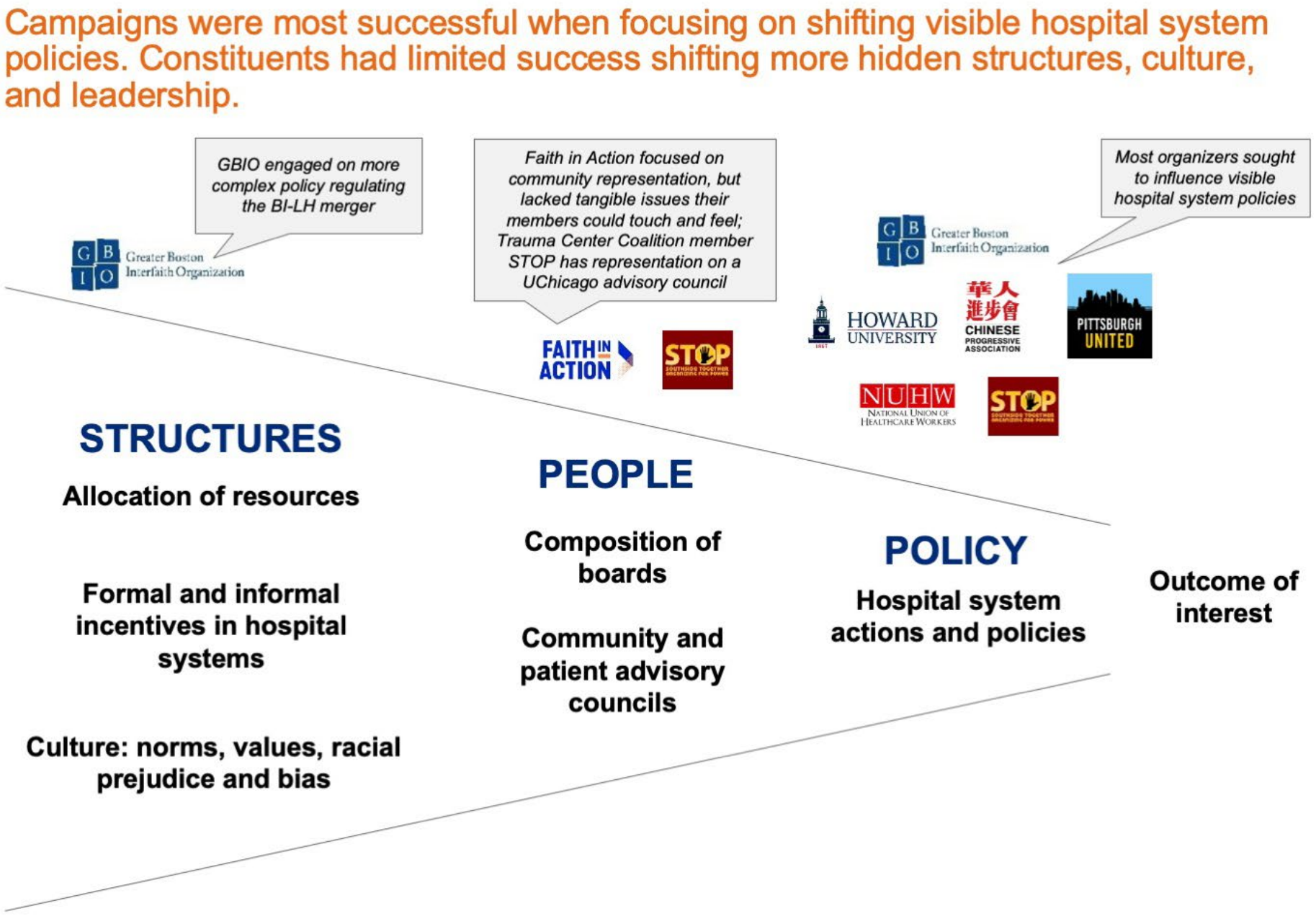
   First, organizers struggle to engage their constituents on more upstream structural issues as opposed to tangible outcomes that members feel more activated by. Paul Hattis from GBIO recalled struggling with getting ordinary congregation members to get excited about the "health care wonk-ish issues" involved in the BI-LH merger: "It's hard to connect that the six percent premium increases are due to things like hospital price variation…and we will fail if we don't include in our advocacy things people can touch and feel, such as insulin prices."[41] In response, GBIO is currently launching a campaign to re-engage its congregations, focused this time on hospital surprise medical billings, affordable mental health care, and prescription drugs—issues that more members are directly struggling with. Similarly, Faith in Action struggled to engage its wider congregations around placing members on patient and family advisory boards.

   Second, organizers lack relationships with hospital system insiders. Due to the closed nature of hospital systems, many organizers lacked inside allies, such as executives and physician leaders, during their campaigns. Even after having achieved remarkable victories requiring substantial investments, many organizers never met senior hospital system leaders. Despite the organizers' desire to meet and discuss solutions with hospital system executives, hospital leaders seemed to express reluctance. Alex Goldenberg, Executive Director of Southside Together Organizing for Power, attributes their reluctance perhaps to a "lack of familiarity around the multiple hats community leaders are able to wear and to sit, negotiate and create joint value." As a result, there was not open communication and exchange about the underlying interests, values, and structural impediments hospital systems faced. This may have impeded learnings on all sides, including the opportunities for organizers to more strategically change structures influencing hospital systems.

   One potential inside ally group that was missing from many coalitions was physicians. During UPMC's community benefits campaign, Pittsburgh United could not find a physician to testify and lend credibility to its health claims. Lisa Frank alleges that this was because, "In the past, when an independent physician has spoken out against UPMC in an op-ed, UPMC threatened to pull admitting privileges from their practice. They have a different risk calculation than us [nurses, service workers] and have a different type of expectation for their life."[42]

   Merlin Chowkwanyun, a public health historian and professor at Columbia University, studies physician activism and explained that the limitations of physician organizing are in part due to the hierarchical nature of the profession and the risk-averse nature of physicians after taking out large medical loans. "The medical degree is still a surefire degree for financial stability, and I'm not sure many would want to rock the boat in their own hospitals," Chowkwanyun said. Furthermore, he explained that medical school activists experience turnover as students graduate and do not carry their activism forward into their careers.[43]

FIGURE 3


Campaigns were most successful when focusing on shifting visible hospital system policies. Constituents had limited success shifting more hidden structures, culture, and leadership.
GBIO engaged on more complex policy regulating the BI-LH merger
Greater Boston Interfaith Organization
Faith in Action focused on community representation, but lacked tangible issues their members could touch and feel; Trauma Center Coalition member STOP has representation on a UChicago advisory council
FAITH IN ACTION
STOP
Most organizers sought to influence visible hospital system policies
Greater Boston Interfaith Organization
HOWARD UNIVERSITY
華人進步會 CHINESE PROGRESSIVE ASSOCIATION
PITTSBURGH UNITED
NUHW NATIONAL UNION OF HEALTHCARE WORKERS
STOP
STRUCTURES
Allocation of resources
Formal and informal incentives in hospital systems
Culture: norms, values, racial prejudice and bias
PEOPLE
Composition of boards
Community and patient advisory councils
POLICY
Hospital system actions and policies
Outcome of interest

2. *Organizing efforts have focused on single-sector rather than multisector stakeholders.*
   Organizing efforts to influence hospital systems have typically focused solely on hospital systems as a stakeholder (except for pushing elected officials to regulate hospital systems). While this singular focus has allowed organizers to effectively pressure hospital systems to fulfill their responsibilities, this also means that organizers have inevitably framed problems and solutions too narrowly. This is because responsibility for the root causes of their claims is often distributed across multiple sectors. For example, rising health care costs in Boston, while driven in large part by hospital systems, are symptomatic of a broader issue in our health care system involving other competitor hospital systems, insurers, pharmaceutical companies, and physician groups.

   Another example: the need for a trauma center in Chicago represented deeper issues of poverty, violence, and racial segregation for which sectors beyond hospital systems (e.g., Chicago city government, housing authority, and the university itself) are also responsible. Members of the Trauma Center Coalition are now turning their attention to negotiating community benefits agreements around the bigger context of UChicago's planned expansion impacts. They are bringing up the displacement of low-income, Black communities on the south and west sides of Chicago.

3. *Organizing efforts lack institutionalization and consistency.*
   On the one hand, the organizing tradition allows for more organic and bottom-up problem nomination. On the other hand, organizing entities often lack the institutionalization and resources required to influence hospital systems on a long-term and consistent basis. "UPMC has immense strategic planning power with a 20-year plan, while we don't have full-time staff. So we are, in a sense, more reactive; we have to be more resourceful," said Lisa Frank of SEIU HCPA.[44] Furthermore, she reflected that, "Training members to run for city council would be the next step, but we currently lack the capacity as volunteers to get organized enough." As large hospital systems follow trends toward increasing consolidation, they will rescale to encompass larger geographies and larger resources. This may present a greater challenge for city-based organizing entities.

   Faith in Action's Hot Spotter initiative generated significant learning about engaging constituents in hospital system decision making, but the initiative ended after the grant from The Atlantic Philanthropies ended. Still, most constituents have continued to build on their work with hospital systems.

SECTION SIX

Appendixes

1. *References to Landmark Documents Discussing the Efficacy of Organized Social Movements*
2. *List of Interview Subjects*
3. *Broad Scan of Health-Related Organizing*
4. *Barriers to Community Organizing Focused Specifically on Hospital Systems*

APPENDIX 1

References to Landmark Documents Discussing the Efficacy of Organized Social Movements

- Julia Airey, "Amendment Would Allow GWU, Howard University Partnership on New Hospital in Ward 8." *The Washington Times*, December 4, 2018, https://www.washingtontimes.com/news/2018/dec/4/george-washington-university-howard-could-partner-/.
- Bob Bauder, "AG Shapiro: UPMC's 'Corporate Greed' Hurting Patients." *TribLIVE.com*, February 18, 2019, https://triblive.com/news/pittsburgh-allegheny/ag-josh-shapiro-files-legal-challenge-against-upmc-highmark-dispute/.
- Martha Bebinger, "Massachusetts Passes Health Cost Control Bill," *Kaiser Health News and WBUR*, July 31, 2012. https://khn.org/news/mass-health-cost-control-bill/.
- Robert Becker, "COUNTY URGED TO FUND HEALTH CARE FOR NEEDY." *Chicago Tribune*, August 29, 2018, https://www.chicagotribune.com/news/ct-xpm-1999-11-09-9911090159-story.html.
- Chelsea Conaboy, "Boston Groups Call for Freeze on Health Premiums," *The Boston Globe*, June 30, 2011, http://archive.boston.com/news/local/massachusetts/articles/2011/06/30/boston_groups_call_for_freeze_on_health_premiums/.
- Julia Conley, "To Galvanize Local Push for Medicare for All in 2019, Nurses' Union Organizing Nationwide 'Barnstorms," *Common Dreams*, December 31, 2018, https://www.commondreams.org/news/2018/12/31/galvanize-local-push-medicare-all-2019-nurses-union-organizing-nationwide-barnstorms.
- Alia E. Dastagir, "Will Your Therapist Go on Strike? 4,000 Mental Health Workers Protesting Kaiser Permanente," *USA Today*, December 17, 2018, https://www.usatoday.com/story/news/nation/2018/12/07/kaiser-permanente-strike-mental-health-workers-california-therapists/2225472002/.
- "Economic Development," Bon Secours, accessed April 6, 2020, https://bonsecours.com/richmond/community-commitment/economic-development.
- Marshall Ganz, "Organizing and Social Change," Lecture presented at the Harvard Kennedy School, Cambridge MA, March 2019
- "Greater Boston Interfaith Organization," First Church Cambridge, accessed March 6, 2020, https://www.firstchurchcambridge.org/first-church-in-the-world/greater-boston-interfaith-organization.
- Paul A Hattis, "Partners Is like a Shark – Always on the Move," *CommonWealth Magazine*, February 25, 2019, https://commonwealthmagazine.org/opinion/partners-is-like-a-shark-always-on-the-move/.
- "Hospital Accountability Project." Community Catalyst, accessed March 7, 2020. https://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project.
- Christopher Huffaker, "A March for Unions and Higher Wages Ahead on Labor Day," *Pittsburgh Post-Gazette*, September 4, 2017, https://www.post-gazette.com/local/city/2017/09/04/labor-day-Pittsburgh-minimum-wage-unions-fast-food-hospitals-education-protestrally-march/stories/201709040095.
- Alex Kacik, "Beth Israel-Lahey Health Merger Clears Final Approval with Conditions," *Modern Healthcare*, November 29, 2018, https://www.modernhealthcare.com/article/20181129/NEWS/181129916/beth-israel-lahey-health-merger-clears-final-approval-with-conditions.
- Beth Kassab, "Part 4: Should Florida Look at Hospital Tax Reform? Other States Are," *Orlando Sentinel*, June 11, 2018, https://www.orlandosentinel.com/opinion/os-hospital-tax-other-states-beth-kassab-20160205-column.html.
- Bill Haley, "Modern Nonprofit Hospitals Are Essentially Legal Fiction' Writes NJ Judge," *Philanthropy Daily*, November 13, 2015, https://www.philanthropydaily.com/modern-nonprofit-hospitals-are-essentially-legal-fiction-writes-nj-judge/.
- Rebecca Nuttall, "Pittsburgh-Based UPMC to Raise Minimum Wage at Most Facilities to $15 per Hour by 2021," *Pittsburgh City Paper*, March 29, 2016, https://www.pghcitypaper.com/pittsburgh/pittsburgh-based-upmc-to-raise-minimum-wage-at-most-facilities-to-15-per-hour-by-2021/Content?oid=1906232.
- "OPIOID CAMPAIGN - LI-CAN," Long Island Congregations, Associations and Neighborhoods, accessed March 6, 2020, https://www.li-can.org/issues-action/.
- "ProMedica, LISC Launch $45M Partnership," ProMedica, March 13, 2018, https://www.promedica.org/news/promedica-lisc-launch-45m-partnership.
- Emily Rappleye, "How Congress, Hospitals and Lobbying Inflate Healthcare Costs: Lobbying and Political Negotiating Have a Surprisingly Direct Effect on U.S. Healthcare Spending, According to a Working Paper Published by the National Bureau of Economic Research and Featured in

The New York Times," *Becker's Hospital Review*, November 1, 2017, https://www.beckershospitalreview.com/hospital-management-administration/how-congress-hospitals-and-lobbying-inflate-healthcare-costs.html.

- Liz Reid, and Kathleen J. Davis. "City Council Approves UPMC Mercy Expansion, Despite Outrage From Community," *WESA Pittsburgh NPR*, July 31, 2018, https://www.wesa.fm/post/city-council-approves-upmc-mercy-expansion-despite-outrage-community.
- Kristen Sschorsch and Claire Bushey, "The Inside Story of Why U of C Medicine Changed Its Mind about a Trauma Center #Uofctrauma," *Crain's Chicago Business*, April 11, 2016, https://www.chicagobusiness.com/static/section/trauma-power.html.
- Sharon Vavra, "Boston Chinatown's Gentrification Linked Historically to Tufts Medical Center's Expansion," *The Tufts Daily*, December 4, 2014, https://tuftsdaily.com/features/2014/12/03/boston-chinatowns-gentrification-linked-historically-tufts-medical-centers-expansion/.
- Lena Weiner, "Why UPMC Is Raising Its Minimum Wage to $15 Per Hour," *Health Leaders*, April 18, 2016, https://www.healthleadersmedia.com/strategy/why-upmc-raising-its-minimum-wage-15-hour.

APPENDIX 2
List of Interview Subjects

Interview stakeholders included representatives from 33 organizing entities, universities, nonprofit organizations, think tanks, and hospital systems.

1. Alex Goldenberg (Executive Director, Trauma Center Coalition, STOP), in discussion with author, April 9, 2019.
2. Amika Tendaji (Organizer and Activist, Trauma Center Coalition, STOP), in discussion with author, March 11, 2019.
3. Amy Hulberg (Former Public Policy Specialist at Health Leads, The Health Initiative) in discussion with author, November 24, 2018.
4. Anthony Galace (Health Equity Director, The Greenlining Institute), in discussion with author, November 9, 2018.
5. Beja Alisheva (Organizer, National Union of Healthcare Workers), in discussion with author, May 6, 2019.
6. Bob Marra (Community Health Manager, Cambridge Health Alliance), in discussion with author, November 7, 2018.
7. Claire Beverly (Journalist), in discussion with author, November 24, 2018.
8. Damon Francis (Chief Medical Officer, Health Leads), in discussion with author, November 29, 2018.
9. Healthcare Principal #1 (Management Consulting firm), in discussion with author, November 2, 2018.
10. Healthcare Principal #2 (Management Consulting firm), in discussion with author, April 7, 2019.
11. Jennifer Rafanan Kennedy (Executive Director, Pittsburgh United), in discussion with author, February 22, 2019.
12. Jeremy Schifberg (Principal, The Health Initiative), in discussion with author, November 24, 2018.
13. Kaytlin Gilbert (Organizer, Physicians for a National Health Plan), in discussion with author, January 2, 2019.
14. Kina Collins (Organizer, Physicians for a National Health Plan), in discussion with author, January 2, 2019.
15. Laura Schmidt (Professor of Health Policy, San Francisco Health Improvement Partnership, UCSF), in discussion with author, January 4, 2019.
16. Lisa Frank (Executive Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.
17. Marcia Hams (Board President, Health Care for All), in discussion with author, January 2, 2019.
18. Meghan Carrier (Lead Organizer, Together Colorado), in discussion with author, February 8, 2019.
19. Meir Lakein (Director of Organizing, Jewish Organizing Institute and Network), in discussion with author, December 6, 2018.
20. Paul Hattis (Member, Greater Boston Interfaith Organization), in discussion with author, December 3, 2018.
21. James Carras (Professor, Harvard Kennedy School), in discussion with author, October 30, 2018.
22. Marshall Ganz (Professor, Harvard Kennedy School), in discussion with author, November 19, 2018.
23. Merlin Chowkwanyun (Professor, Columbia Mailman School of Public Health, in discussion with author, November 27, 2018.
24. Quentin Mayne (Professor, Harvard Kennedy School), in discussion with author, May 6, 2019.
25. Robert Blendon (Professor, Harvard T.H. Chan School of Public Health), in discussion with author, February 4, 2019.
26. Ravahn Samati (Former Union Representative, National Union of Healthcare Workers), in discussion with author, February 15, 2019.
27. Roberto Vargas (Member, SF Health Improvement Partnership, UCSF), in discussion with author, February 11, 2019.
28. Ron Snyder (Director of Organizing, Faith in Action, PICO International), in discussion with author, December 3, 2018.
29. Silas Russell (Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.
30. Stephanie Aines (Director of Organizing & Training, The Lown Institute), in discussion with author, November 9, 2019.
31. Sue Budd (Executive Administrator, ISAIAH Minnesota), in discussion with author, January 3, 2019.
32. Sue Sherry (Executive Director, Community Catalyst), in discussion with author, April 22, 2019.
33. Sydney Fang (Asian Pacific Environmental Network (formerly), in discussion with author, November 16, 2018.

APPENDIX 3
Broad Scan of Health-Related Constituent Organizing

Most health-related organizing efforts are focused on other institutions (not hospital systems) to achieve health care reform, tackle SDoH, and lower prescription drug prices.

Organizers influencing state and national policy makers:

a. Physicians for a National Health Plan (PNHP): With 20,000 members and chapters across the country, PNHP works toward single payer programs in their communities by conducting research, lobbying, coordinating speakers/forums, participating in town halls, and educating community members via "house parties" and organizing rallies.[45]

b. National Nurses United: Nurse union campaigns have been fighting for Medicare for All since 2009. This year, the organization is calling for Medicare for All "barnstorms" to gather volunteers, talk about the plan to win, knock on doors, and make phone calls in support of Democratic Congressional members on an expected Medicare for All bill.[46]

c. Greater Boston Interfaith Organization: GBIO led (along with Health Care for All) efforts to organize its congregations and collect petitions for the eventual successful passage of the Massachusetts health reform law.

d. Greater Cleveland Congregations: In 2012, this organization launched a campaign to expand Medicaid in Ohio. It also created the Northeast Ohio Medicaid Expansion Coalition with hospitals, held a 1,200-person assembly at Olivet Institutional Baptist Church, lobbied, wrote petitions, and collected 2,500 signatures to successfully expand Medicaid.

e. United Power for Action and Justice: In 1999, a grassroots organization of churches, labor unions, and community groups launched a campaign to expand health insurance in the form of primary care to the uninsured in Cook County.[47]

Organizers influence city, education, housing stakeholders:

a. The California Endowment (TCE): TCE has invested $1 billion over 10 years in 14 California communities to build community capacity and power to change policy and systems in schools and neighborhoods (e.g., community development, food security). For example, TCE funded the Richmond Health Equity Partnership (a community and cross-government alliance) that developed a "Health in all Policies" strategy to ensure all city initiatives consider a health equity framework.

b. Healthy Heartlands:[48] A multi-state collaborative of faith-based community organizers and public health professionals to tackle social determinants facing low-income residents and communities of color. It has organized around the framing of health, and on broader issues, such as: ensuring public transit serves low-income communities, improving access to healthy food in urban neighborhoods, improving employment options of formerly incarcerated individuals, ending expulsion and suspension for children of color, and promoting free preschool for low-income kids.

Organizers influence pharmaceutical companies, insurance companies:

a. Right Care Alliance/Lown Institute: A grassroots coalition of clinicians, patients, and community members is currently launching a campaign against Eli Lilly, Sanofi, and Novo Nordisk to reduce high insulin costs. Thus far, the coalition is planning direct action and a postcard-writing campaign.

b. Long Island Congregations, Associations, Neighborhoods: Worked to remove barriers to Medication-Assisted Treatment (MAT) for opioid addiction in the criminal justice system, insurer practices, and treatment system. The region's two largest emergency departments will now be able to provide MAT.[49]

APPENDIX 4
Barriers to Community Organizing Focused Specifically on Hospital Systems

Across the organizing landscape, many constituents are focused on influencing institutions other than hospital systems (e.g., national policy makers, local officials, pharmaceutical companies) to address their health care and SDoH issues. There are a few reasons why.

It does not occur to many constituent organizers that this is an option because there is uncertainty over what should be demanded of hospital systems. Should hospitals focus on delivering on their health care mandate (improving access, affordability, quality) or addressing broader SDoH? "Hospitals just don't come to mind as often in relation to other issues that we're doing through the ballot box, such as bail reform, housing, and other issues,"[50] said Ron Snyder, former executive director of Oakland Community Organization.

Even when it does occur to organizers, they need to decide if the cause is worth the effort of helping constituencies overcome their limited perceptions of hospitals' potential roles. Jeremy Schifberg, from The Health Initiative, an organization spurring new dialogue and investments around a broader notion of health reflected, "it would seem that hospitals would be a natural actor around broader social determinants like food and housing since they ostensibly have a mission around health and often benefit from significant tax benefits in their communities. But this seems to reflect the broader bridge that is difficult for people to cross around what they perceive health is and isn't."[51] Meir Lakein, from Jewish Organizing Institute & Network, said that "so much of organizing is around stories, taking private pain and turning it into public action. Health care and hospitals seem rather theoretical…It's like the environment. It's outrageous how bad it is but seems remote."[52]

Another barrier is the complexity of hospital systems themselves and the lack of understanding about the appropriate levers for influencing hospitals. "It's such a complex system, people don't necessarily know what a hospital can do for them. Perhaps community health centers, which are more trusted in the community, can play a role in helping educate people,"[5 3] said a Chicago reporter who investigates organizing on the city's South Side.

ENDNOTES

[1] Marshall Ganz, "Organizing and Social Change," Lecture presented at the Harvard Kennedy School, Cambridge MA, March 2019

[2] Beth Kassab, "Part 4: Should Florida Look at Hospital Tax Reform? Other States Are," Orlando Sentinel, June 11, 2018, https://www.orlandosentinel.com/opinion/os-hospital-tax-other-states-beth-kassab-20160205-column.html.

[3] Alex Goldenberg (Executive Director, STOP), in discussion with author, April 9, 2019.

[4] Amika Tendaji (Organizer and Activist, Trauma Center Coalition, STOP), in discussion with author, March 11, 2019.

[5] Kristen Sschorsch and Claire Bushey, "The Inside Story of Why U of C Medicine Changed Its Mind about a Trauma Center #Uofctrauma," Crain's Chicago Business, April 11, 2016, https://www.chicagobusiness.com/static/section/trauma-power.html.

[6] Claire Beverly (Journalist), in discussion with author, November 24, 2018.

[7] Alex Goldenberg (Executive Director, STOP), in discussion with author, April 9, 2019.

[8] Schorsch and Bushey, "Why U of C Medicine Changed"

[9] Amika Tendaji (Organizer and Activist, Trauma Center Coalition, STOP), in discussion with author, March 11, 2019.

[10] Alex Goldenberg (Executive Director, STOP), in discussion with author, April 9, 2019.

[11] Alex Goldenberg (Executive Director, STOP), in discussion with author, April 9, 2019.

[12] Alex Goldenberg (Executive Director, STOP), in discussion with author, April 9, 2019.

[13] Schorsch and Bushey, "Why U of C Medicine Changed"

[14] Schorsch and Bushey, "Why U of C Medicine Changed"

[15] Coalition included other players in addition to GBIO and Healthcare for all including SEIU, Boston Center for Independent Living, Fall River New Bedford Community Organizing

[16] Marcia Hams (Board President, Health Care for All), in discussion with author, January 2, 2019.

[17] Paul Hattis (Member, Greater Boston Interfaith Organization), in discussion with author, December 3, 2018.

[18] Bob Marra (Community Health Manager, Cambridge Health Alliance), in discussion with author, November 7, 2018.

[19] Chelsea Conaboy, "Boston Groups Call for Freeze on Health Premiums," The Boston Globe, June 30, 2011, http://archive.boston.com/news/local/massachusetts/articles/2011/06/30/boston_groups_call_for_freeze_on_health_premiums/.

[20] "Greater Boston Interfaith Organization," First Church Cambridge, accessed March 6, 2020, https://www.firstchurchcambridge.org/first-church-in-the-world/greater-boston-interfaith-organization.

[21] Martha Bebinger, "Massachusetts Passes Health Cost Control Bill," Kaiser Health News and WBUR, July 31, 2012. https://khn.org/news/mass-health-cost-control-bill/.

[22] First Church Cambridge, Greater Boston Interfaith Organization.

[23] First Church Cambridge, Greater Boston Interfaith Organization.

[24] Paul A Hattis, "Partners Is like a Shark – Always on the Move," CommonWealth Magazine, February 25, 2019, https://commonwealthmagazine.org/opinion/partners-is-like-a-shark-always-on-the-move/.

[25] Paul Hattis (Member, Greater Boston Interfaith Organization), in discussion with author, December 3, 2018.

[26] An insurance company, offering in Pittsburgh Medicare Advantage plans

[27] Jennifer Rafanan Kennedy (Executive Director, Pittsburgh United), in discussion with author, February 22, 2019.

[28] Lisa Frank (Executive Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.

[29] Silas Russell (Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.

[30] Christopher Huffaker, "A March for Unions and Higher Wages Ahead on Labor Day," Pittsburgh Post-Gazette, September 4, 2017, https://www.post-gazette.com/local/city/2017/09/04/labor-day-Pittsburgh-minimum-wage-unions-fast-food-hospitals-education-protestrally-march/stories/201709040095.

[31] Huffaker, "A March for Unions and Higher Wages"

[32] Rebecca Nuttall, "Pittsburgh-Based UPMC to Raise Minimum Wage at Most Facilities to $15 per Hour by 2021," Pittsburgh City Paper, March 29, 2016, https://www.pghcitypaper.com/pittsburgh/pittsburgh-based-upmc-to-raise-minimum-wage-at-most-facilities-to-15-per-hour-by-2021/Content?oid=1906232.

[33] Bob Bauder, "AG Shapiro: UPMC's 'Corporate Greed' Hurting Patients." TribLIVE.com, February 18, 2019, https://triblive.com/news/pittsburgh-allegheny/ag-josh-shapiro-files-legal-challenge-against-upmc-highmark-dispute/.

[34] Lisa Frank (Executive Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.

[35] Jennifer Rafanan Kennedy (Executive Director, Pittsburgh United), in discussion with author, February 22, 2019.

[36] $15 wage has been perceived as being so slowly phased in that inflation may negate the benefit..

[37] Silas Russell (Vice President, SEIU Healthcare Pennsylvania), in discussion with author, February 22, 2019.

[38] Liz Reid, and Kathleen J. Davis. "City Council Approves UPMC Mercy Expansion, Despite Outrage From Community," WESA Pittsburgh NPR, July 31, 2018, https://www.wesa.fm/post/city-council-approves-upmc-mercy-expansion-despite-outrage-community.

[39] Reid and Davis. "City Council Approves UPMC Expansion"

[40] Jennifer Rafanan Kennedy (Executive Director, Pittsburgh United), in discussion with author, February 22, 2019.

[42] Paul Hattis (Member, Greater Boston Interfaith Organization), in discussion with author, December 3, 2018.

[43] Lisa Frank-SEIU Healthcare Pennsylvania, interview by lueh Soh (author), February 22nd, 2019.

[44] Professor Merlin Chowkwanyun-Columbia, Mailman School of Public Health, interview by Iueh Soh (author), November 27th, 2018.

[45] Other groups include: Healthcare-NOW, Public Citizen, All Unions Committed for Single Payer Healthcare, Labor Campaign for Single Payer, Democratic Socialists of America, Progressive Democrats of America, Single Payer Action, National Health Care for the Homeless Council.

[46] Julia Conley, "To Galvanize Local Push for Medicare for All in 2019, Nurses' Union Organizing Nationwide 'Barnstorms," Common Dreams, December 31, 2018, https://www.commondreams.org/news/2018/12/31/galvanize-local-push-medicare-all-2019-nurses-union-organizing-nationwide-barnstorms.

[47] Bebinger, "Massachusetts Passes Health Cost Control Bill"

[48] Our affiliates are ISAIAH in Minnesota, the Ohio Organizing Collaborative, Michigan Power to Thrive, WISDOM in Wisconsin, MissouriFaith Voices, Faith in Florida, and the Micah Project in Louisiana.

[59] "OPIOID CAMPAIGN - LI-CAN," Long Island Congregations, Associations and Neighborhoods, accessed March 6, 2020,

[50] Ron Snyder (Director of Organizing, Faith in Action, PICO International), in discussion with author, December 3, 2018.

[51] Jeremy Schifberg (Principal, The Health Initiative), in discussion with author, November 24, 2018.

[52] Meir Lakein (Director of Organizing, Jewish Organizing Institute and Network), in discussion with author, December 6, 2018.

[53] Claire Beverly (Journalist), in discussion with author, November 24, 2018.