



INTERIM REPORT

Restoring Our Regional Hospital

*Community and Public-Health Impact of the Closure, and the Case
for Restoring a Regional Acute Care Hospital in Norwood*

A Report of the Norwood Hospital Task Force

June 22, 2026

CONTENTS

THE NORWOOD HOSPITAL TASK FORCE	3
Executive Summary	4
Background: What Happened to Norwood Hospital.....	6
1.1 The 2020 Flood and the Closure of Norwood Hospital	7
1.2 Current Status: The Hospital Remains Unfinished.....	9
The Community and Public Health Impact.....	11
2.1 The Demand Did Not Disappear — It Was Redistributed	12
2.2 Reaching Emergency Care Now Takes Significantly Longer.....	14
2.3 The Loss of Cardiac Intervention Capacity	17
2.4 The Receiving System Was Already Strained.....	18
2.5 Job Losses and Economic Impact.....	20
2.6 Community Experience and Needs	21
Recommendations.....	24
3.1 The Objective.....	25
3.2 The Commonwealth Should Lead the Response.....	25
3.3 Primary Recommendation: Enactment of the State Eminent-Domain Legislation (H.5192).....	26
3.4 Contingency: Acquisition by the Town of Norwood	26
Conclusion	28
Appendix A — Inpatient discharges by community of residence	30
Appendix B — Emergency medical services metrics by town	31

LIST OF EXHIBITS

Exhibit 1.1 Norwood Hospital’s core service area.....	8
Exhibit 1.2 How a region lost its hospital: the flood and the corporate collapse.....	10
Exhibit 2.1 Where Norwood’s patients went: discharges of catchment residents at the major receiving hospitals	13
Exhibit 2.2 Occupancy at the absorbing hospitals, FY2019 vs. FY2023	14
Exhibit 2.3 Timely hospital arrivals fell most in the towns closest to the Norwood Hospital site	15
Exhibit 2.4 Ambulance crews are tied up longer: the share of runs with the crew back in service within 45 minutes fell across the catchment	17
Exhibit 2.5 Emergency-department boarding rose across every measure, 2020–2024 20	
Exhibit 2.6 Residents’ reported impacts of the closure, 2026 community survey	22

WHO PREPARED THIS REPORT

THE NORWOOD HOSPITAL TASK FORCE

The Norwood Hospital Task Force was convened in 2025 at the direction of **Governor Maura Healey**. The working group was charged with documenting the state of health-care access across the region served by Norwood Hospital and with helping to identify a qualified operator to restore acute care at the site.

We know that Norwood and the region relied on Norwood Hospital, which has been left in limbo for years due to flood damage and Steward's mismanagement. I welcome the creation of this working group and look forward to collaborating in this work to ensure access to high-quality health care in Norwood and the region.

— Governor Maura Healey

TASK FORCE MEMBERS

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EXECUTIVE SUMMARY

Norwood Hospital served the Town of Norwood and surrounding communities — a region of roughly 250,000 people — as a full-service acute care hospital for more than a century. In its last full year of operation it earned a profit of \$25.0 million, and it handled more than 39,000 emergency department visits and over 10,000 inpatient discharges.

On June 28, 2020, a catastrophic flood forced the hospital's emergency evacuation, and it has never reopened. The reconstruction that followed was halted when its operator, Steward Health Care, entered bankruptcy. The site, now owned by an Alabama-based real estate investment trust, remains an unfinished shell.

Nearly six years on, the region remains without local acute care — through no decision of the communities that depend on it. This report documents the consequences of that loss and proposes a path to restore Norwood Hospital.

Emergency care now takes significantly longer to reach patients. Across the core towns of the catchment area, the share of ambulance transports reaching a hospital within 30 minutes fell from 52% before the closure to 29% afterward. The decline was most severe in the areas closest to the hospital site: in Norwood it fell from 87% to 38%, and in Walpole from 68% to 11%. Median transport times rose correspondingly — in Walpole, from 26 minutes to 39 — and because each transport now occupies an ambulance crew for a longer round trip, fewer units are available to answer the next call.

The loss is sharpest for the most time-critical emergencies. Norwood was among roughly two dozen hospitals statewide equipped to perform percutaneous coronary intervention — the artery-opening procedure that is the definitive treatment for a major heart attack. The two hospitals that absorbed the largest share of Norwood's patients cannot perform it and must transport cardiac patients onward to Boston, adding a further delay in circumstances where minutes are decisive. Norwood Hospital also provided critical services for patients suffering strokes, who must now be transported to more distant hospitals for extremely time-sensitive treatment.

The displaced demand fell on a system with little room to absorb it. Norwood's demand was redistributed across surrounding hospitals, several of which were already near capacity — one absorber, Beth Israel Deaconess Hospital–Needham, was operating at 93% occupancy by 2023. That local strain reflects a documented statewide condition: emergency-department boarding in Massachusetts rose sharply between 2020 and 2024, and the state's own Health Policy Commission has identified the loss of hospital beds from recent closures as a threat to regional capacity.

The harm is regional, and the remedy belongs at the state level. Because the loss crosses municipal boundaries and burdens hospitals well beyond Norwood, it is appropriately addressed by the Commonwealth and should not be the burden of a single town.

The Task Force strongly supports enactment of H.5192, the legislation authorizing the Commonwealth to acquire the Norwood Hospital property by eminent domain and return it to hospital use under a qualified operator. Should the legislation not advance, the Task Force recommends that the Town of Norwood consider acquiring the property through its municipal eminent domain authority and identifying a qualified operator through an open process.

The communities Norwood Hospital served lost their hospital and its acute care services to a natural disaster. A chain of corporate failures outside their control has compounded the consequences of this disaster and denied a region access to vitally necessary healthcare services.

The evidence in this report establishes that the loss is real, measurable, and ongoing — and that restoring acute care to the region is a matter of regional public health that warrants action by the Commonwealth.

Before and After the Closure of Norwood Hospital (2019 → 2023-24)

52% → **29%**

AMBULANCE TRANSPORTS REACHING
A HOSPITAL WITHIN 30 MIN
(10 TOWN CATCHMENT AREA)

65% → **93%**

INPATIENT OCCUPANCY AT THE
LARGEST ABSORBING HOSPITAL
(BID-NEEDHAM)

70% → **24%**

AMBULANCES BACK IN SERVICE WITHIN
45 MINUTES
(NORWOOD)

SECTION 1

BACKGROUND: WHAT HAPPENED TO NORWOOD HOSPITAL

Norwood Hospital was a profitable, century-old community hospital serving roughly 250,000 people across the region when a June 2020 flood forced its evacuation and demolition.

Reconstruction began but the process collapsed when its operator, Steward Health Care, stopped paying contractors and entered bankruptcy. Nearly six years on, the site remains an unfinished shell and the region is still without vital acute care services.

1.1 The 2020 Flood and the Closure of Norwood Hospital

Norwood Hospital served the Town of Norwood and the surrounding region as a full-service acute care community hospital for more than 100 years. It operated inpatient medical, surgical, maternity, and psychiatric units, a 24-hour emergency department, an intensive care unit, and a cardiac catheterization laboratory. Its catchment area encompassed approximately 250,000 residents across the region. In fiscal year 2019, the last full year before its closure, the hospital recorded 10,354 inpatient discharges, 39,444 emergency department visits, and 63,155 outpatient visits.¹

The hospital was financially sound at the time of its closure. The Center for Health Information and Analysis, the Commonwealth's official health-data agency, reported that Norwood Hospital generated a profit in each fiscal year from 2015 through 2019 — including \$11.2 million in 2018 and \$25.0 million in 2019, on total revenue of \$203.7 million and a total margin of 12.3% in 2019.² In 2019, 64.4% of its patient service revenue derived from public payers, a measure of how heavily the region's most vulnerable residents relied on it.³ By every financial measure, the hospital was a stable institution providing vital services to its community.

Norwood Hospital did not close because it failed. It closed because of a natural disaster. On June 28, 2020, a severe storm dropped nearly six inches of rain in a matter of hours, and catastrophic flooding inundated the hospital, causing extensive damage to its lower levels and mechanical systems. Patients were evacuated under emergency conditions, in the middle of the COVID-19 pandemic, with mutual-aid support from dozens of surrounding communities. In a single night, an event outside anyone's control removed a profitable, fully functioning hospital from a region of a quarter-million people. The building was rendered unusable, and the hospital has been closed to patient services ever since.

At the time of the flood, the hospital was operated by Steward Health Care — a Dallas-based, for-profit health system — under a lease with an affiliate of Medical Properties Trust (“MPT”), an Alabama-based real estate investment trust that owned the underlying real estate. Steward sought to rebuild. On August 30, 2021, the Massachusetts Department of Public Health (“DPH”) issued an Emergency Determination of Need authorizing construction of a replacement hospital, including a replacement cardiac catheterization laboratory.⁴ The damaged building was demolished and construction began. By mid-2023, work on the foundation, the structural frame, and building utilities had been completed.⁵

¹ Center for Health Information and Analysis, Steward Norwood Hospital Profile (FY2019). <https://www.chiamass.gov/assets/docs/r/hospital-profiles/2019/norwood.pdf>. The figure of roughly 250,000 residents is an approximation of Norwood Hospital's service-area population. The quantitative analysis in this report is based on the ten core service-area communities — Canton, Dedham, Foxborough, Mansfield, Norfolk, Norwood, Sharon, Walpole, Westwood, and Wrentham — identified from fiscal year 2019 CHIA discharge data as the ten communities accounting for the largest numbers of the hospital's inpatient discharges, although Norwood Hospital served residents beyond these ten communities as well.

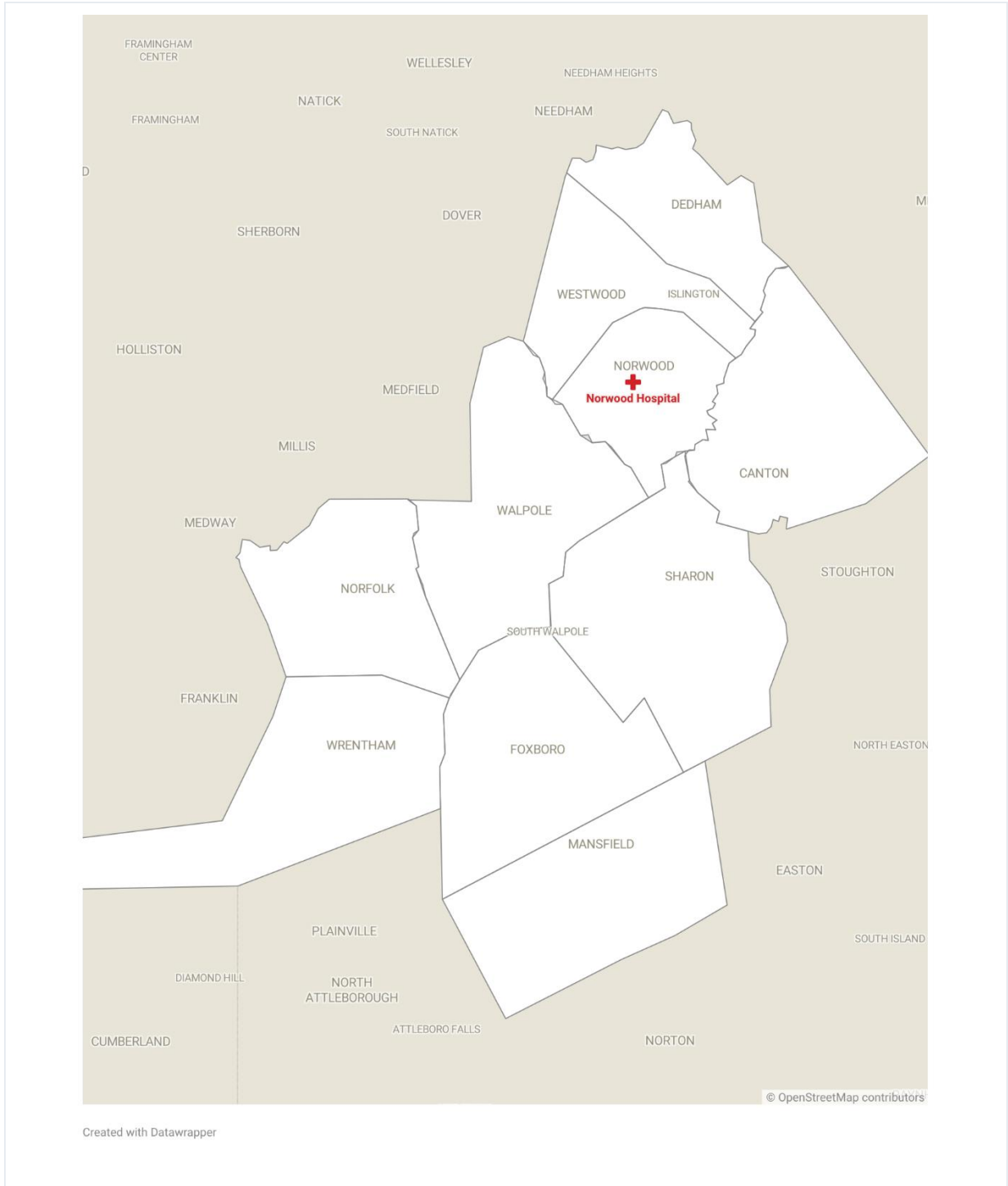
² Center for Health Information and Analysis, Steward Norwood Hospital Profile (FY2019) (see note 1).

³ Center for Health Information and Analysis, Steward Norwood Hospital Profile (FY2019), payer-mix data (see note 1).

⁴ Massachusetts Department of Public Health, Emergency Determination of Need No. 20121611 (Aug. 30, 2021). <https://www.mass.gov/lists/steward-health-care-systems-llc-emergency-don-norwood-hospital>.

⁵ Contemporaneous reporting (Boston Globe; CBS Boston), 2024.

Exhibit 1.1 Norwood Hospital’s core service area



Norwood Hospital provided critical health care services to a population of roughly 250,000 residents across the region.

Source: Center for Health Information and Analysis, Steward Norwood Hospital Profile (FY2019). Core service area shown as the ten communities with the largest numbers of inpatient discharges from the hospital in FY2019.

1.2 Current Status: The Hospital Remains Unfinished

Construction halted in February 2024, when contractors and subcontractors ceased work after Steward stopped paying them.⁶ In May 2024, Steward Health Care filed for Chapter 11 bankruptcy protection, part of a broader collapse that led the company to sell or close its hospitals across Massachusetts and other states. Control of the Norwood site passed to MPT. In October 2024, Steward filed notice with DPH of its intent to abandon the Norwood property and to close four affiliated outpatient satellite clinics; the hospital's license expired on November 5, 2024.⁷ The Emergency Determination of Need authorizing the rebuild has since lapsed, and any future operator of the site must obtain a new Determination of Need from DPH before the hospital can reopen.

As of the date of this report, the site at 800 Washington Street remains an unfinished construction project. The building's exterior shell was, at one point, substantially complete, although the effects of the elements on the unfinished building remain a concern. The interior is unbuilt, requiring full mechanical, electrical, and plumbing systems, interior finishes, and all medical equipment before it could function as a hospital. The property is owned by an affiliate of MPT — a real estate company — and not by any hospital operator. In connection with the closure, DPH found that Norwood Hospital was “an essential service necessary for preserving access and health status within the Hospital's service area.”⁸ Nearly six years after a flood first forced its doors closed, the communities that depended on Norwood Hospital remain without local acute care — through no decision of their own.

⁶ Boston Globe, “Norwood hospital construction on pause as vendors await payments from Steward” (Feb. 21, 2024), <https://www.bostonglobe.com/2024/02/21/business/steward-norwood-hospital-construction-non-payment/>.

⁷ Steward notice of intent to close, filed with DPH (Oct. 11, 2024), <https://www.mass.gov/doc/norwood-notice-of-intent-to-close-2-pdf-norwood-hospital/download>; Steward Norwood Hospital Transition and Closure Plan (Sept. 25, 2024), <https://www.mass.gov/doc/norwood-closure-plan-pdf/download>.

⁸ Massachusetts DPH, Review of Closure Plan — Norwood Hospital (Oct. 29, 2024) (finding made pursuant to M.G.L. c. 111, § 51G and 105 CMR 130.122[E]), <https://www.mass.gov/doc/dph-response-to-closure-plan-pdf-norwood-closure/download>. For the regulatory framework, see 105 CMR 130.122, <https://www.mass.gov/regulations/105-CMR-13000-hospital-licensure>.

Exhibit 1.2 How a region lost its hospital: the flood and the corporate collapse



THE FINDING A profitable hospital was lost to a flood, then kept closed by its operator's bankruptcy — not by any failure of the hospital itself.

Source: Task Force chronology drawn from DPH records, Steward and MPT filings, bankruptcy-court records, and H.5192.

SECTION 2

THE COMMUNITY AND PUBLIC-HEALTH IMPACT

The roughly 250,000 residents of the communities near Norwood Hospital did not stop needing hospital care after the building flooded.

This section documents where the displaced demand went, how much longer care now takes to reach patients, what those delays mean to the residents of the area, and the strained condition of the system left to absorb it.

The roughly 250,000 residents of Norwood Hospital’s catchment did not stop needing hospital care after the building flooded in June 2020. Much of the demand the hospital had served was redistributed to other hospitals. This section documents where that demand went, how much longer it now takes patients to reach care, what those delays mean to local residents, and the condition of the regional system left to absorb the displaced volume.

A PATIENT’S ACCOUNT

“On January 6, 2025, I suffered a stroke at home while babysitting our two young grandchildren. My wife immediately called 911. Norwood Fire and EMT were incredibly fast and provided excellent care. I was lucky — it was midweek, little traffic — and I was driven right past the closed Norwood Hospital to BID-Needham, and then ambulated into Boston. I should never have had to leave my community during a medical emergency where every minute mattered.”

— Mike Connors, Norwood resident, retired hospital CFO, and stroke survivor

2.1 The Demand Did Not Disappear — It Was Redistributed

In its last full year of operation, Norwood Hospital discharged approximately 6,600 inpatients who resided in the ten core towns of its primary service area.⁹ After the closure, those patients were redistributed across surrounding hospitals. The Center for Health Information and Analysis (CHIA) publishes an annual profile for every acute-care hospital in Massachusetts, including a breakdown of inpatient discharges by patient community of residence. Comparing the fiscal year 2019 profiles (the last full year before the flood) with fiscal year 2023 and 2024 indicates, hospital by hospital and town by town, where the displaced patients went.¹⁰

Beth Israel Deaconess Hospital–Needham absorbed the largest share. Its discharges of patients from the ten catchment towns rose from approximately 920 in 2019 to approximately 2,930 in 2024.¹¹ In the Town of Norwood, BID–Needham moved from roughly the eighth-largest hospital destination to the first: Norwood-resident discharges there grew from 145 to more than 1,000.¹² Discharges from Needham’s own residents were stable-to-declining over the same period, so the growth came from outside its home community.

Newton-Wellesley Hospital was the second-largest absorber. Norwood-resident discharges there rose from about 350 in 2019 to more than 480 by 2024, with comparable increases from Walpole, Westwood, and Sharon.¹³ The hospital’s total inpatient discharges rose approximately 15%, and its occupancy increased from the mid-50% range to nearly 80%.

The remaining volume dispersed. Beth Israel Deaconess Medical Center in downtown Boston — an academic medical center rather than a community hospital — recorded a sharp rise in Norwood-resident discharges, indicating that some catchment patients now travel into Boston for inpatient

⁹ Derived from CHIA Acute Hospital Profiles (FY2019), summing Norwood Hospital’s own discharges across the ten catchment towns. <https://www.chiamass.gov/massachusetts-acute-hospital-profiles/>.

¹⁰ CHIA Acute Hospital Profiles, FY2019, FY2023, and FY2024, discharges-by-community tables, with additional data relating to the ten core service-area towns provided to the Task Force in connection with a public records request to CHIA (as set forth in Appendix A).

¹¹ CHIA Acute Hospital Profiles, FY2019 and FY2024, discharges-by-community tables (see note 10); Appendix A.

¹² CHIA Acute Hospital Profiles, FY2019 and FY2024, discharges-by-community tables (see note 10); Appendix A.

¹³ CHIA Acute Hospital Profiles, FY2019 and FY2024, discharges-by-community tables (see note 10); Appendix A.

care previously available locally. Patients from the catchment’s southeastern edge, principally Canton, appeared at BID–Milton.¹⁴

Exhibit 2.1 Where Norwood’s patients went: discharges of catchment residents at the major receiving hospitals



THE FINDING No single hospital replaced Norwood. The catchment fractured by geography — each town’s patients shifted to other nearby hospitals, with BID–Needham absorbing the largest single share.

Source: CHIA hospital discharge data by community of residence, FY2019 and FY2024 (Appendix A). Ten core service-area towns.

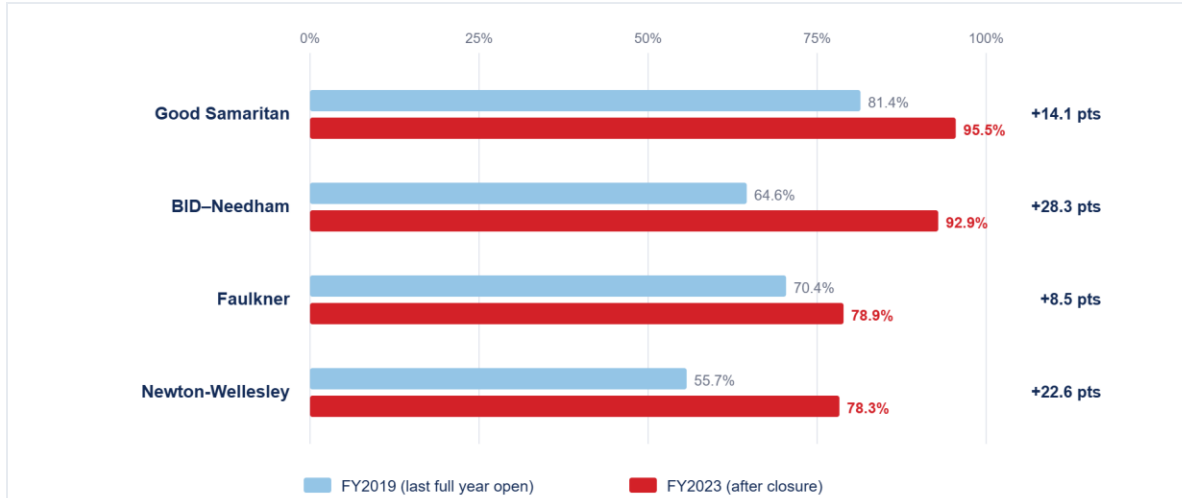
The redistribution did not move Norwood’s patients into a system with room to receive them. Several of the hospitals that absorbed the largest shares were operating at or near full occupancy by 2023. The figures below are drawn from the same CHIA hospital profiles.

Hospital	Inpatient occupancy, FY2019	Inpatient occupancy, FY2023
BID–Needham	64.6%	92.9%
Good Samaritan (Brockton)	81.4%	95.5%
Newton-Wellesley	55.7%	78.3%
Brigham and Women’s Faulkner	70.4%	78.9%

Source: CHIA Acute Hospital Profiles, FY2019 and FY2023.

¹⁴ CHIA Acute Hospital Profiles, FY2019 and FY2024, discharges-by-community tables (see note 10); Appendix A.

Exhibit 2.2 Occupancy at the absorbing hospitals, FY2019 vs. FY2023



THE FINDING The displaced demand landed on hospitals already near capacity — BID-Needham reached 93% occupancy and Good Samaritan 95% by 2023.

Source: CHIA Acute Hospital Profiles, FY2019 and FY2023. Occupancy is annual inpatient occupancy.

BID-Needham — the nearest hospital for much of the catchment and the largest single absorber — rose from roughly two-thirds full to 93% occupancy. Good Samaritan reached 95%. An inpatient hospital operating in the low-to-mid 90s percent has little practical reserve: it is effectively full on a typical day and has minimal ability to absorb surges.

This local picture sits within a documented statewide trend. The Massachusetts Health Policy Commission (HPC), the state's independent health-policy agency, reports that between fiscal years 2016 and 2023 the number of staffed acute-care beds in Massachusetts grew by 3.0% while average daily census grew by 9.6% — producing higher occupancy and fewer available beds, with the increase concentrated in the eastern half of the state, the region that absorbed Norwood's volume.¹⁵ The closure of Norwood Hospital added a quarter-million people's worth of demand to this system as its available capacity was strained. The patients were absorbed into hospitals that had less room to receive them.

2.2 Reaching Emergency Care Now Takes Significantly Longer

The most immediate consequence of the closure falls on emergency medical services. With no hospital in Norwood, ambulances carrying patients from the catchment must travel farther to reach an emergency department. State EMS data quantifies the result.¹⁶

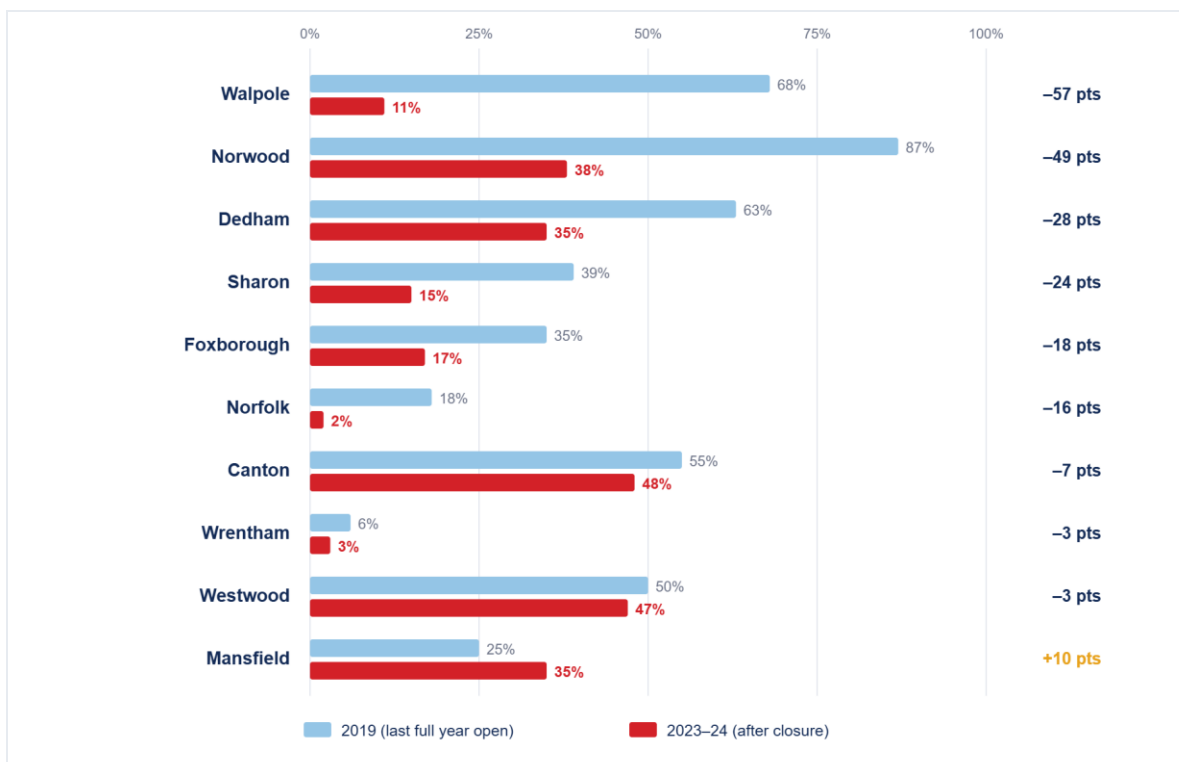
¹⁵ Massachusetts Health Policy Commission, analysis of CHIA hospital discharge and case-mix data (Feb. 2025 report and subsequent material). https://masshpc.gov/sites/default/files/2025-02/20250227_BH-ED-Boarding_o.pdf.

¹⁶ DPH/Office of Emergency Medical Services, Massachusetts statewide EMS data for the ten primary-service-area towns, calendar years 2019, 2023, and 2024. Data provided to the Task Force in response to a public records request and is set forth in partial form in Appendix B. The under-30-minute measure is the share of transported runs with a unit-notified-to-ED-arrival interval below 30 minutes. The "2023-24" figures are averages of the two post-closure years, computed from raw run counts (the qualifying transports across 2023 and 2024 divided by the total transported runs across both years). For the Town of Norwood, for example, 2,287 of

The standard measure is the share of ambulance transports that reach a hospital within 30 minutes, measured from the time the crew is dispatched to arrival at the emergency department. Across the ten core towns of the catchment, that share fell from 52% in 2019, the last full year Norwood Hospital was open, to 29% in 2023–2024.¹⁷ Before the closure, a majority of emergency transports reached a hospital within half an hour; afterward, fewer than one in three did.

In the Town of Norwood, the share of transports reaching a hospital within 30 minutes fell from 87% to 38%. In Walpole, it fell from 68% to 11%. The towns closest to the former hospital — Norwood, Walpole, Dedham, Sharon — show the largest declines. The data reflects proximity to a hospital, and the towns that lost their nearest one lost the most.

Exhibit 2.3 Timely hospital arrivals fell most in the towns closest to the Norwood Hospital site



THE FINDING Across the ten towns, transports reaching a hospital within 30 minutes fell from 52% to 29% — and the decline tracked distance from the closed hospital.

Source: Massachusetts statewide EMS data, 2019 vs. 2023–24 average (Appendix B). Measured dispatch to ED arrival.

2,640 transports reached a hospital within 30 minutes in 2019 (87%); after the closure, 1,229 of 3,456 did so in 2023 and 1,530 of 3,843 in 2024, a combined 2,759 of 7,299, or 38%. Crew-availability figures (the share of runs with the unit back in service within 45 minutes) are derived the same way.

¹⁷ Massachusetts statewide EMS data (see note 16); ten-town aggregate, share of transports reaching a hospital within 30 minutes. 2019: 9,925/18,946 = 52.4%→52%; 2023–24 pooled: 11,892/41,348 = 28.8%→29%.

“Our first responders are currently under immense strain. Because Norwood is closed, they must transport patients to Boston, Needham, Newton, or Brockton. These round trips consistently exceed one hour and sometimes two.”

— **Jim O’Neill**, Walpole Select Board

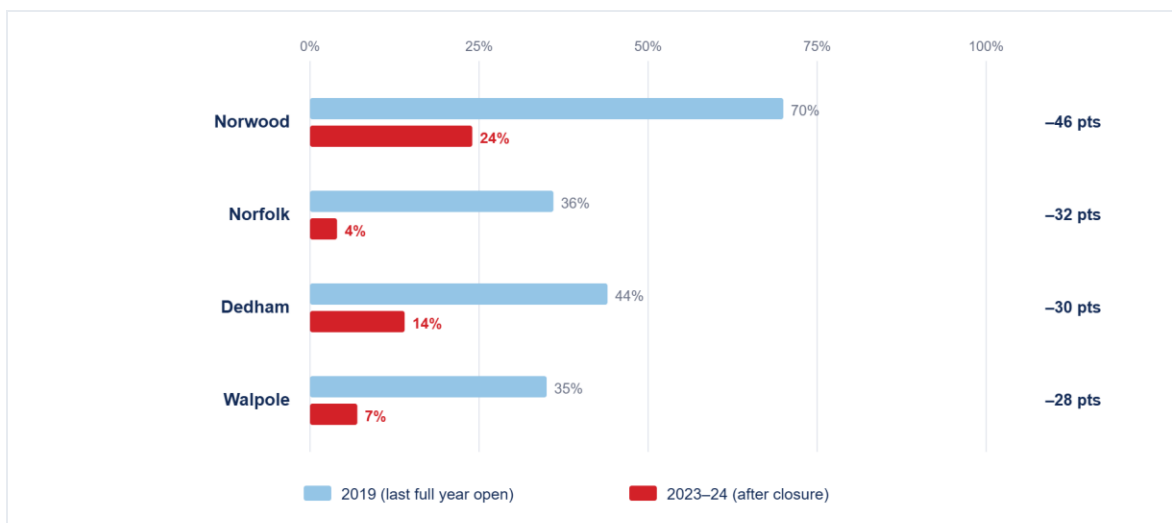
Median transport times rose correspondingly. In the Town of Norwood, the median time from dispatch to emergency-department arrival increased from 20 minutes in 2019 to 31 minutes in 2024.¹⁸ In Walpole it rose from 26 to 39 minutes, in Sharon from 31 to 37, and in Norfolk from 37 to 45. The typical emergency transport in these communities now takes materially longer than it did when Norwood Hospital was open. These additional minutes carry particular weight for time-sensitive emergencies. For conditions such as stroke, heart attack, and major trauma, the interval between onset and treatment is a recognized determinant of survival and recovery.

The closure also reduced the availability of ambulances for subsequent calls. Because each transport now ties up a crew and vehicle for a longer round trip, units return to service more slowly. In the Town of Norwood, the share of runs after which the crew was back in service within 45 minutes fell from 70% in 2019 to 24% in 2023–2024.¹⁹ The same pattern holds across the catchment: in Walpole, from 35% to 7%; in Dedham, from 44% to 14%; in Norfolk, from 36% to 4%. A longer transport delays the patient in the ambulance; the resulting unavailability of that ambulance delays the response to the next emergency in the community.

¹⁸ Massachusetts statewide EMS data (see note 16); median unit-notified-to-ED-arrival interval by town; Appendix B.

¹⁹ Massachusetts statewide EMS data (see note 16); share of runs with the unit back in service within 45 minutes; Appendix B.

Exhibit 2.4 Ambulance crews are tied up longer: the share of runs with the crew back in service within 45 minutes fell across the catchment



THE FINDING Longer round trips keep crews unavailable — in Norwood, the share of runs with the crew back within 45 minutes fell from 70% to 24%, delaying the response to the next call.

Source: Massachusetts statewide EMS data, 2019 vs. 2023–24 average (Appendix B). Crew availability after each transport.

These figures reflect a durable change. They held steady or worsened in most towns from 2023 to 2024, several years after the closure, even as total EMS call volume across the ten towns rose by approximately 10%.²⁰ The closure of Norwood Hospital is the principal driver of the deterioration, particularly for the towns nearest the former hospital; it is not, given the regional growth in call volume, the sole factor. The magnitude and geographic concentration of the change point to the closure as its primary cause.

“Longer return times from distant hospitals limit ambulance availability for subsequent emergencies, resulting in regional service gaps.”

— Tom Henderson, Director of EMS, Professional Firefighters of Massachusetts

2.3 The Loss of Cardiac Intervention Capacity

The emergency-access loss documented above is sharper for one category of patient than the general figures convey. Among the services Norwood Hospital provided was a cardiac catheterization laboratory capable of percutaneous coronary intervention (PCI) — the artery-opening procedure that is the definitive treatment for a major heart attack. For a heart attack, the decisive interval is the time to reopening the blocked artery, and that procedure can be performed only at a hospital with a catheterization lab.

²⁰ Massachusetts statewide EMS data (see note 16); total EMS runs across the ten towns, 2019 vs. 2024; Total runs 23,234 → 25,508 = +9.8%.

DEFINITION — PERCUTANEOUS CORONARY INTERVENTION (PCI)

The artery-opening procedure that is the definitive treatment for a major heart attack. It can be performed only at a hospital with a cardiac catheterization laboratory — a capability Norwood had and its two largest absorbers do not.

Norwood Hospital was among roughly two dozen hospitals in Massachusetts equipped to perform PCI.²¹ Its catheterization laboratory handled 428 cases in its last full year of operation, and the rebuild authorized by the state’s Determination of Need included a replacement catheterization lab with two procedure rooms.²² The facility was part of a small statewide network of hospitals equipped to treat the most time-critical cardiac emergencies.

The hospitals that absorbed the largest shares of Norwood’s displaced patients cannot perform this procedure. Neither Beth Israel Deaconess Hospital–Needham nor Newton-Wellesley Hospital — the two largest absorbers identified in Section 2.1 — appears on the state’s list of PCI-capable hospitals. BID–Needham states the limitation directly in its own patient materials: for cardiac catheterization, it provides “rapid transport to BIDMC in Boston.”²³ A heart-attack patient who reaches the nearest receiving hospital must, in these cases, be stabilized and transported a second time to a hospital that can perform the intervention — adding a further interval to the time-critical sequence.

“If you have a heart attack in Norwood, Walpole, Wrentham, Sharon, Canton, Dedham, Foxborough, or Mansfield, you are 40 minutes from getting the appropriate care. The best hospitals in the world do not matter if patients can’t reach them.”

— **Tony Mazzucco**, General Manager, Town of Norwood; Chair, Norwood Hospital Task Force

The 30-minute mark is a meaningful benchmark for emergency cardiac care, and the catchment no longer meets it. As documented above, the share of ambulance transports across the ten towns reaching any hospital within 30 minutes has fallen from 52% to 29%. Because most of the hospitals now receiving these patients cannot perform PCI, the effective time to a hospital that can treat a heart attack is longer still — and for much of the catchment, well beyond the half-hour mark.

2.4 The Receiving System Was Already Strained

The preceding sections established that Norwood’s patients were absorbed by hospitals that were, in several cases, already near full. That local picture reflects a broader condition: the regional system that received the displaced demand was, over the same period, experiencing a documented and worsening shortage of capacity.

²¹ Massachusetts Data Analysis Center (Mass-DAC), Adult PCI in Massachusetts (most recent published state roster, FY2014 data), which lists 24 such hospitals; the count is cited here as approximate given the age of the available data. <https://www.mass.gov/doc/pci-hospital-report-2014/download>.

²² Massachusetts DPH, Emergency Determination of Need No. 20121611, memorandum to the Commissioner (Aug. 30, 2021), recording 428 cardiac catheterization cases (see note 4).

²³ Beth Israel Deaconess Hospital–Needham, patient information materials. <https://bidneedham.org/services/emergency-care>.

DEFINITION — EMERGENCY-DEPARTMENT BOARDING

Holding a patient in the emergency department for an extended period because no appropriate inpatient bed is available. The Health Policy Commission counts an ED stay of 12 or more hours as boarding.

The clearest measure is emergency-department boarding — the practice of holding admitted patients in the emergency department for extended periods because no appropriate inpatient bed is available. Massachusetts defines a boarding episode as a wait of more than 12 hours in the ED.²⁴ The HPC reports that the share of emergency-department visits resulting in boarding rose from 6.6% in 2020 to 9.9% by early 2024.²⁵ For non-behavioral-health visits specifically, the share grew from 4.5% in 2020 to 8.1% by early 2024.²⁶ The Massachusetts Health & Hospital Association reports that, on a typical day, more than 1,000 patients statewide cannot move to the next appropriate level of care and remain in hospital beds they no longer need.²⁷

This matters to the question of Norwood Hospital because it describes the environment into which the hospital's demand was redistributed. The closure did not shift patients into a system with spare capacity; it added demand to a system already short of beds. The HPC has separately identified the loss of hospital beds from recent closures as a threat to statewide capacity, noting that the August 2024 closures of Carney and Nashoba Valley Hospitals removed approximately 129 beds and that it is tracking the effect of such closures on inpatient capacity.²⁸ The loss of Norwood Hospital's beds is a loss of the same kind.

“There was no state plan, desire, or process regarding the closure of Norwood’s inpatient beds.”

— **Julie Pinkham, RN**, former Executive Director, Massachusetts Nurses Association

²⁴ Massachusetts Health Policy Commission, Behavioral Health Emergency Department Boarding in Massachusetts (Feb. 27, 2025), p. 8 (see note 15).

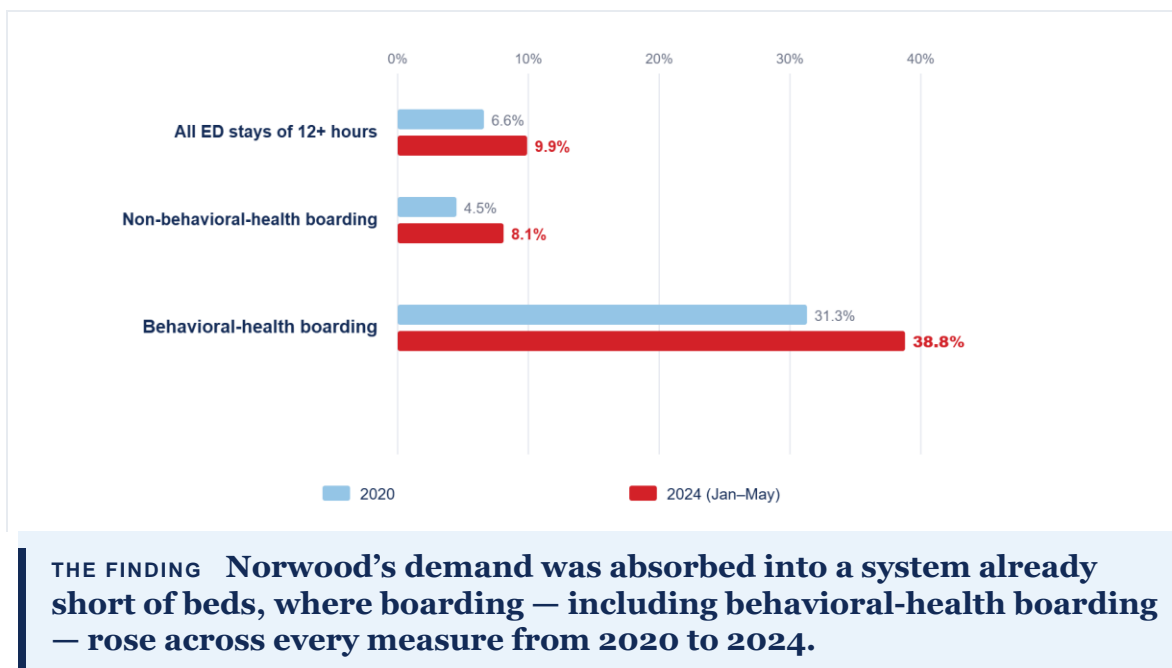
²⁵ Massachusetts Health Policy Commission, Behavioral Health Emergency Department Boarding in Massachusetts (Feb. 27, 2025), p. 8 (see note 15).

²⁶ Massachusetts Health Policy Commission, Behavioral Health Emergency Department Boarding in Massachusetts (Feb. 27, 2025), p. 8 (see note 15).

²⁷ Massachusetts Health & Hospital Association. <https://www.mhalink.org/throughputreports/>.

²⁸ Massachusetts Health Policy Commission, Behavioral Health Emergency Department Boarding in Massachusetts (Feb. 27, 2025), p. 4 (see note 15).

Exhibit 2.5 Emergency-department boarding rose across every measure, 2020–2024



Source: Massachusetts Health Policy Commission, boarding analysis (Feb. 2025).

The point of this section is not that Norwood’s closure caused the statewide boarding crisis; the data is regional and statewide, and the closure is one contributor among several. The point is that the demand displaced by the closure was absorbed into a system with little room to receive it.

2.5 Job Losses and Economic Impact

The closure’s effects extend beyond health care. According to testimony from the Neponset River Regional Chamber of Commerce, Norwood Hospital employed more than 1,000 people at the time of its closure, and the resulting job losses removed tens of millions of dollars from the local economy.²⁹ The loss of those positions, and of the spending they supported, removed a significant economic presence from the area. The hospital also anchored a surrounding network of physician practices and specialists, a number of which have since closed or relocated.³⁰

These negative economic consequences are self-evident, if difficult to fully quantify. For the purposes of this report, the economic dimension is noted as a real and ongoing cost of the closure, secondary to but compounding the public-health harms that are its primary subject.

The region’s demand for hospital care, meanwhile, is not receding. The ten core towns of the catchment added approximately 21,000 residents between 2000 and 2023, growth of 11.3 percent, ahead of the Commonwealth’s 10.3 percent over the same period.³¹ Housing construction has continued since the closure, with approximately 1,375 units permitted across those ten towns

²⁹ Testimony of the Neponset River Regional Chamber of Commerce, Feb. 12, 2026 hearing.

³⁰ Testimony of the Neponset River Regional Chamber of Commerce, Feb. 12, 2026 hearing.

³¹ Population figures from U.S. Census Bureau decennial counts (2000, 2010, 2020) and the 2023 American Community Survey one-year estimate, accessed via the Massachusetts Housing Partnership’s DataTown tool. Ten-town figure derived by summing the ten core service-area communities from the catchment-area population table.

between 2020 and 2023.³² The population the hospital was built to serve is larger today than at any point in its operating history, and the units now permitted will add to it.

2.6 Community Experience and Needs

A community health survey conducted in 2026 provides a record of how the residents of the area report experiencing the loss themselves.

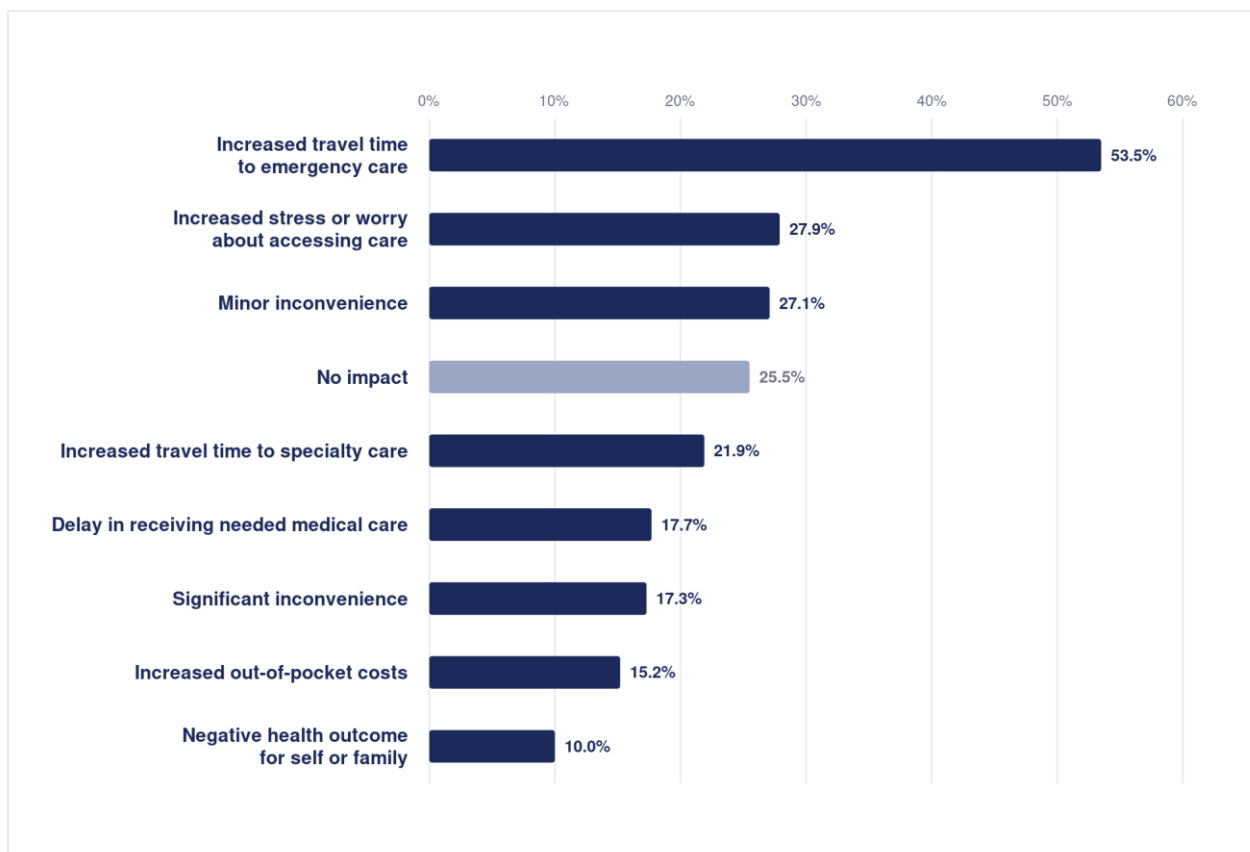
As part of its 2026 Community Health Assessment, the Norfolk County 8 Public Health Coalition surveyed residents and workers concentrated in five catchment towns — Norwood, Canton, Dedham, Walpole, and Westwood.³³ Asked how the closure of Norwood Hospital had affected them or their families, 53.5% of respondents reported increased travel time to access emergency care — the most frequently reported impact, and the same condition Section 2.2 documents in the state's EMS data. 27.9% reported increased stress or worry about accessing care, and 17.7% reported a delay in receiving needed medical care. Roughly one quarter reported no impact.³⁴

³² Massachusetts Housing Partnership, DataTown (Housing Production), drawing on the U.S. Census Bureau Annual Building Permits Survey (reported and imputed values). Ten-town figure derived by summing the ten core communities from the service-area permit table; permitted units are not all yet constructed.

³³ Norfolk County 8 Public Health Coalition, Community Health Survey (2026), preliminary findings presented June 10, 2026; provided to the Task Force by the Town of Norwood Director of Public Health. N=474 respondents reporting residence and/or workplace in the five towns. A voluntary community survey; results reflect respondents' reported experience and perception.

³⁴ Norfolk County 8 Public Health Coalition Community Health Survey (2026), impact question, N=462; respondents could select all impacts that apply.

Exhibit 2.6 Residents' reported impacts of the closure, 2026 community survey



THE FINDING The most common impact residents report — longer travel to emergency care (53.5%) — is the same condition the state's EMS data documents in Section 2.2.

Source: Norfolk County 8 Public Health Coalition Community Health Survey (2026), preliminary findings. Respondents could select all that apply.

The survey also measured confidence. Asked how confident they were of receiving timely care for a serious or life-threatening emergency, fewer than one in four respondents (23.5%) answered "very confident." 44.9% were at most somewhat confident, including 15.1% who were not at all confident.³⁵ Nearly one in three respondents (31.6%) reported that meeting their medical needs would require travel outside their local community.³⁶

Asked what areas of medical care the community needs, 79.8% of respondents identified emergency and hospital care — the leading response by a wide margin, and among respondents from the Town of Norwood, 93.0%.³⁷ Preventative care (37.9%), cardiovascular care (32.0%), women's health (28.6%), pediatric care (22.7%), and cancer care (20.4%) followed. The community's stated needs

³⁵ Norfolk County 8 Public Health Coalition Community Health Survey (2026), confidence question, N=463.

³⁶ Norfolk County 8 Public Health Coalition Community Health Survey (2026), access question, N=462.

³⁷ Norfolk County 8 Public Health Coalition Community Health Survey (2026), areas-of-need question.

correspond to the services Norwood Hospital provided, and to the service lines identified in Section 3.1.

These findings are residents' reported experience and perception. The burdens residents describe — longer emergency transports, strain on local ambulance services, the loss of local physicians and specialists — are the same conditions reflected in the data in Sections 2.1 through 2.4.

"It's so reassuring to have that resource right down the street, especially in the event when minutes can be life or death."

— Survey respondent, Norfolk County 8 Community Health Survey (2026)

SECTION 3

RECOMMENDATIONS

The harm from the closure is serious, regional, and ongoing — and it will persist until acute-care services are restored at the site.

The Task Force’s recommendations have a single objective: returning a 24-hour emergency department, inpatient capacity, and cardiac care to the 800 Washington Street site under a qualified operator.

Its primary recommendation is enactment of H.5192, authorizing the Commonwealth to acquire the property by eminent domain — with a local acquisition as the contingency if the state path does not advance.

The evidence in this report supports a single conclusion: the communities formerly served by Norwood Hospital have sustained a serious and ongoing loss of access to emergency and acute care, and that loss will persist until hospital services are restored at the site. The Task Force's recommendations follow from that conclusion.

3.1 The Objective

The objective is the restoration of acute-care hospital services — including a 24-hour emergency department, inpatient capacity, and interventional cardiology capability including at least one cardiac catheterization laboratory — at the 800 Washington Street site, under a qualified operator. Beyond those core services, the Task Force seeks the restoration of full-service hospital operations comparable to or exceeding those Norwood Hospital historically provided. The Task Force has identified particular community interest in oncology services, diagnostic imaging services, stroke care, surgical services, and maternity and obstetric services.

3.2 The Commonwealth Should Lead the Response

Section 2 establishes that the harm from the closure is serious, regional, and continuing. This section explains why addressing it may require action by the Commonwealth, and why that action is prudent and in the best interests of the general public.

Restoring an acute-care hospital is critical for regional public health. The losses this report documents are not correcting themselves. Emergency transport times have not improved since the closure, and many of the hospitals absorbing Norwood's patients are operating at or near capacity. The region's gaps in emergency care, cardiac care, and other critical needs remain. These conditions will continue for as long as Norwood Hospital remains closed.

Public intervention is necessary to break the current impasse and remedy the deleterious impact on public health and the general welfare, as private enterprise alone has failed to act.

The reasons for the failure of the private owner to reopen Norwood Hospital are not clear, nor are they even relevant at this time. What matters today is that to reopen the hospital, construction must be completed and a qualified healthcare operator secured. The owner has not disclosed a plan to complete construction or one to reopen the hospital, nor are there plans to engage a third-party health care operator to undertake the construction project and then operate the hospital. Consequently, six years after its closure, the hospital is closed, its shell remains unfinished, subject to the elements, with no plan to complete construction, and no health care operator engaged to operate the hospital even if the building was finished. As a result, ready access to health care, a hallmark of living in Massachusetts, has been eroded for some citizens, and for others slipped out of reach entirely.

The regional scope of the harm to the public health and general welfare compels public action. The hospital served approximately 250,000 residents across the region; the increase in transport times reaches across that region; and the displaced demand burdens hospitals well beyond Norwood. A problem that crosses municipal lines and strains a regional system is properly addressed at the regional level, and the Commonwealth is the level of government suited to it. A single municipality cannot be expected to resolve a problem of this scope on its own. This is why the Task Force looks first to the Commonwealth.

Public action is necessary and proper to remediate conditions detrimental to the public health. Time is of the essence. The demand a restored hospital would serve is documented and current. The health needs of the area's residents did not end with the closure. They have been absorbed by surrounding hospitals now operating at or near capacity, as Section 2 shows, and some residents, facing longer trips and more distant care, have likely gone without treatment they would otherwise have sought. The need is visible in present-day data.

The site's history reinforces the point. Before the flood, Norwood Hospital was a successful institution, operating profitably in each of its last five years and earning a surplus of \$25.0 million on a 12.3 percent margin in its final full year. It closed because of a flood and its operator's later bankruptcy, not because the hospital itself was failing. A restored hospital would serve a market with documented, unmet need, on a site that has supported a working hospital before.

The structure of the remedy reflects this. Under the legislation the Task Force recommends, the Commonwealth would not build or operate the hospital. It would acquire the site and transfer it to a qualified operator who completes construction and runs the facility. The state's role is not to invest in a hospital but to clear the obstacle that has kept one from being finished.

3.3 Primary Recommendation: Enactment of the State Eminent-Domain Legislation (H.5192)

The Task Force supports enactment of H.5192, the bill authorizing the Division of Capital Asset Management and Maintenance to acquire the Norwood Hospital property by eminent domain.³⁸ The bill supplies the reasonably necessary authority described in the preceding section to promote and protect public health, safety and welfare by facilitating the redevelopment, reestablishment and reopening of a full service, acute care hospital in Norwood to deliver high-quality health care services to the general public. As of this writing, it has been reported favorably out of the Joint Committee on State Administration and Regulatory Oversight and referred to the House Committee on Ways and Means.³⁹

The legislation is a measured step. Under the bill, the Commonwealth would not operate the hospital. Once acquired, the property would be transferred to a qualified nonprofit operator that completes construction and runs the facility.

Qualified potential operators have expressed interest in completing the Norwood Hospital site to the Task Force. This legislation provides the path.

3.4 Contingency: Acquisition by the Town of Norwood

If the Commonwealth does not act, the Task Force recommends that the town of Norwood consider acquiring the property through its own eminent domain authority in order to redress the deleterious impact on the health of the people of Norwood and the general public. In addition, the Task Force recommends that the town of Norwood consider taking such steps as may be deemed reasonably necessary to ensure the redevelopment, reestablishment and reopening of Norwood Hospital,

³⁸ H.5192, 194th General Court (reported favorably by the Joint Committee on State Administration and Regulatory Oversight, Mar. 5, 2026; referred to House Ways and Means). <https://malegislature.gov/Bills/194/H5192.pdf>.

³⁹ H.5192 bill history, 194th General Court (reported favorably, Mar. 5, 2026; referred to the House Committee on Ways and Means).

including identifying a qualified hospital operator through an open process to carry out the public health and welfare objectives. This also allows the town of Norwood to ensure that a qualified operator with the necessary expertise and resources is willing to finish the project and operate the hospital. The Town has begun preparing for that possibility and has retained legal counsel and appropriated funds to cover certain legal and professional expenses related to an operator solicitation process, and, if necessary, an eminent domain taking.

This municipal path is a fallback, not the preferred course. For the reasons given in Section 3.2, a regional harm is best addressed at the regional level, and a town-led acquisition would place on a single municipality a burden that is properly the Commonwealth's. The Task Force is prepared to support a town-led process if the state path does not succeed.

SECTION 4

CONCLUSION

The closure removed acute and emergency care from a region of roughly 250,000 people, and the consequences are real, measurable, and continuing.

They include longer ambulance transport times across the catchment, the loss of the region's cardiac-intervention capacity, and the redistribution of a quarter-million people's demand onto a system with little room to absorb it. Nearly six years on, these conditions persist, and so does the case for a regional remedy. The Task Force urges enactment of H.5192 to return the site to hospital use under a qualified operator.

The closure of Norwood Hospital removed acute and emergency care from a region of roughly 250,000 people. The evidence assembled in this report — drawn from the Commonwealth’s own records — establishes that the consequences are real, measurable, and continuing: longer ambulance transport times across the catchment, the loss of the region’s cardiac intervention capacity, and the redistribution of a quarter-million people’s demand onto a surrounding system with little room to absorb it. These are not transitional disruptions. Nearly six years after the flood, they persist.

The harm is regional, and so is the case for a regional remedy. The Task Force urges the enactment of H.5192, authorizing the Commonwealth to acquire the Norwood Hospital property by eminent domain and return it to service under a qualified operator. The property has sat unfinished and unopened for years while the communities it was built to serve have borne the cost; the legislation offers a path to resolution that no longer depends on the agreement of an owner that has neither reopened the hospital nor transferred it to one who would. Should that path not advance, the Town of Norwood stands prepared to pursue acquisition through its own authority, after identifying a qualified hospital operator through an open solicitation process.

The communities that depended on Norwood Hospital did not choose to lose it, and they cannot restore it on their own. The Commonwealth has the authority to act. The Task Force urges that it do so.

Appendix A — Inpatient discharges by community of residence

Town	Year	Total	Norwood Hosp.	BID–Needham	BIDMC (Boston)	BID–Milton	Newton-Well.	B&W (Brigham)	Faulkner	Good Samaritan
Norwood	2019	4,300	2,021	145	328	15	352	391	167	24
	2023	3,439	–	897	529	48	435	480	212	171
	2024	3,515	–	1,080	622	44	487	366	154	111
Dedham	2019	3,137	348	426	471	37	301	440	493	15
	2023	2,897		582	452	28	397	522	481	
	2024	2,976		637	469	31	400	499	447	
Walpole	2019	2278	955	61	157	18	275	277	70	13
	2023	1728		358	238	14	381	221	68	137
	2024	1863		449	291	22	360	247	82	85
Canton	2019	2746	687	36	287	278	196	287	89	209
	2023	2559		67	304	430	266	346	86	423
	2024	2634		112	307	581	266	320	91	306
Foxborough	2019	1757	641		117	25	110	257	109	24
	2023	1600		50	132	14	232	262	94	138
	2024	1719		53	111	12	260	312	108	91
Mansfield	2019	1984	436	15	89	11	113	293	64	121
	2023	1836		22	98	12	170	315	40	221
	2024	1835		28	89	12	195	302	60	167
Norfolk	2019	895	283	22	65		146	108	20	
	2023	870		53	66		216	132	32	21
	2024	853		58	77		193	96	23	16
Sharon	2019	1528	458	55	177	23	144	206	46	73
	2023	1327		142	129	28	200	200	46	306
	2024	1388		134	159	43	218	217	49	288
Westwood	2019	1452	326	162	181	14	238	204	79	
	2023	1324		293	190	14	310	277	77	
	2024	1289		357	206		301	201	80	
Wrentham	2019	1349	468		35		86	164	32	13
	2023	1149		21	46		127	188	34	22
	2024	1172		22	51		132	170	38	14
Ten towns	2019	21,426	6,623	922	1,907	421	1,961	2,627	1,169	492
	2023	18,729	–	2,485	2,184	588	2,734	2,943	1,170	1,439
	2024	19,244	–	2,930	2,382	745	2,812	2,730	1,132	1,078

Column key: BID–Needham = Beth Israel Deaconess Hospital–Needham. BIDMC = Beth Israel Deaconess Medical Center, Boston. BID–Milton = Beth Israel Deaconess Hospital–Milton. B&W = Brigham and Women’s Hospital, Boston (distinct from Faulkner). “Ten towns” = sum across all ten core service-area towns. Columns show the principal receiving hospitals and do not sum to the total.

Source: Massachusetts Center for Health Information and Analysis, data requested by Task Force in a public records request (received Sept. 2025).

Appendix B — Emergency medical services metrics by town

Town	Year	Median dispatch-to-ED arrival (min)	% of transports reaching a hospital < 30 min	% of crews back in service < 45 min
Norwood	2019	20	86.6	69.8
	2023	32	35.6	23.6
	2024	31	39.8	23.5
Dedham	2019	31	63.3	43.7
	2023	33	36	14.5
	2024	33	34.9	14.4
Walpole	2019	26	67.8	35
	2023	38	11.7	7.5
	2024	39	10	6.3
Canton	2019	29	55.3	22.6
	2023	30	48.5	19.1
	2024	30	47.9	18.4
Foxborough	2019	33	35.1	16.5
	2023	38	17.4	9.5
	2024	38	17.1	8.4
Mansfield	2019	35	24.9	39.7
	2023	32	35.2	19.2
	2024	32	35	21.9
Norfolk	2019	37	17.7	35.7
	2023	44	1.1	4.2
	2024	45	2	4.3
Sharon	2019	31	38.5	14.1
	2023	38	14.5	10.2
	2024	37	14.6	9.2
Westwood	2019	29	50.1	24.3
	2023	30	46.6	29.2
	2024	30	48.3	33.7
Wrentham	2019	42	5.7	6.7
	2023	41	3.8	2.8
	2024	43	3	4.3

Source: Massachusetts DPH/Office of Emergency Medical Services, data requested by Task Force in a public records request (received Dec. 2025).