
# Holding On:
## Fighting to Preserve Essential Services at a Community Hospital

*A manual for advocates by advocates, based on the closure of Waltham Hospital in Waltham, Massachusetts*

HealthLawAdvocates
Fighting for Health Care Justice

Community Catalyst



**By Alex Sugerman-Brozan and Laurie Martinelli,**
**Health Law Advocates, October 2003**

Many thanks to Tony Mangini, Dianne Koch, Kelly Cooper,
Regina Rockefeller, Ruth Gately, Bob Marra and
all the members of the Coalition to Save Waltham Hospital.
Special thanks to Dawn Touzin for her excellent editing assistance.

**This manual was made possible by the support of Community Catalyst and by a grant from the W.K. Kellogg Foundation**

**Community Catalyst** *(www.communitycatalyst.org)* is a nonprofit, national health care advocacy organization dedicated to building consumer and community participation in the decisions that shape the health system to ensure quality, affordable health care for all. It is working with consumer advocates around the country to expand health care access, improve health care quality, preserve health care resources amid hospital and health plan restructuring, strengthen the capacity of consumer health advocacy groups, and build state and regional networks to work for needed policy and system change.

One of Community Catalyst's key initiatives is the Community Health Assets Project (CHAP), which is carried out in conjunction with the West Coast Regional Office of Consumers Union. CHAP seeks to protect nonprofit charitable health assets and community-based health services when nonprofit health care institutions seek to become for-profit or otherwise restructure. CHAP coaches consumer groups intervening in these and other kinds of transactions, such as hospital closings, health plan mergers, and HMO bankruptcies. CHAP also works with these groups to ensure that the new foundations resulting from such conversions are set up to be responsive to the health needs of their communities and provide for public participation in foundation decision-making. CHAP has worked with consumer groups in 42 states since 1996, helped preserve over $16 billion in community health assets, and helped to enact conversion laws in 23 states. CHAP also focuses on community benefits and free care campaigns to ensure that health care institutions provide needed services to the community.

**Health Law Advocates, Inc. (HLA)** *(www.hla-inc.org)* is a public interest law firm founded in 1996. HLA is affiliated with Health Care For All, a premier consumer advocacy organization whose mission is to build a movement of empowered people and communities, with the goal of creating a health care system that is responsive to the needs of all people.

HLA is the only nonprofit law firm in the country affiliated with a grassroots health care access organization and dedicated solely to ensuring access to health care for society's most vulnerable members, including the chronically ill and uninsured.

HLA provides free legal representation to vulnerable Massachusetts residents seeking adequate health care services. We also fight for health care justice through the representation of groups of consumers and communities and through education and outreach.

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# *FOREWORD*

This manual is the result of the hard work that was done by community residents, activists, and local organizations in 2001 when they faced the proposed shutdown of their local hospital in Waltham, Massachusetts. Their experience reflects the ongoing challenges to communities as their health care institutions maneuver in a landscape increasingly affected by market forces – a landscape where the number of uninsured, underinsured, and barriers to access are also increasing.

Community Catalyst has worked with state and local groups across the country, providing technical and organizational assistance, to ensure that consumers give voice to their interests and focus public attention on health care access, quality, and affordability. The work documented in this manual parallels efforts we have seen elsewhere in Springfield, Oregon; Salem, New Jersey; and Kansas City, Missouri. The Waltham story can be instructive to any community fighting to preserve local health care services.

In this case, the community's efforts paid off. The hospital did stay open for another year. Although the facility ultimately closed, advocates were able to highlight the services that were essential to local residents, and they bought time to find ways to pressure state officials and nearby facilities to mitigate the closing's impact on health care access.

Whether the hospital is nonprofit or for-profit, a community health center, a public hospital, or a multi-facility system, the interests of the community and the importance of giving voice to those concerns remains the same – essential services must remain accessible and affordable to all, and an organized and concerted community voice can make a difference.

As health care corporations emulate the behavior of other markets, profits and size are all too often becoming their driving goals. But when the focus shifts from Main Street to Wall Street, the fallout can profoundly affect local services. However, the community does not have to watch helplessly. The message in this manual is clear: in the famous words of activist Joe Hill, "Don't mourn, organize."

Dawn Touzin
*Community Catalyst*

# I. Introduction

What can a community do when faced with a hospital closure, either complete or partial? Clearly, legislative and regulatory reforms are needed on both the national and local level to address the crisis of hospital closures and the loss of hospital services. But what are the specific steps that health care advocates, community members, local officials and hospital staff can take to preserve vital hospital services in their communities?

### *The goal of this manual*

The goal of this manual is to help you organize your community when your local hospital is either going to discontinue individual services or units or close entirely. We use our experience in Massachusetts as a model. Massachusetts has a strong state law that requires a hospital to take a number of steps prior to closing or eliminating "essential services." Your state law and regulations may vary significantly from ours in Massachusetts. You may not even have an "essential services" law. Nonetheless, you can still use organizing and public pressure to keep a hospital open or reduce a closure's impact – wherever you are, the principles and steps we articulate in this guide will hold true.

### *How to approach a campaign to preserve essential hospital services*

The most important lesson we've learned from our work in Massachusetts is that preserving essential services is a matter of political will, organizing savvy, and creative problem-solving. It does not require having the perfect law or the ideal regulations (although those help!). It is best summarized by the statement attributed to Franklin Delano Roosevelt, who, upon being lobbied for a particular measure, reportedly told its proponents, "Ok, you've convinced me. Now go out and force me." This guide aims to show you how to use the tools of community organizing to generate public pressure to preserve hospital services. Our experience shows that with sufficient public and community pressure and creative organizing, a hospital closure or partial closure can be opposed.

### *The disastrous effects of a local hospital shutting its doors*

Hospitals in the United States have been shutting down at an alarming rate. In Massachusetts, we have lost 19 hospitals since 1991. The loss of a hospital is devastating to a local community: not only does it mean the loss of good jobs, it can also seriously jeopardize the health of local residents. A hospital closure can be especially disastrous for a rural area, since it may be the only accessible site for emergency and routine medical services within a several-hour drive. Rural or urban, a hospital closure hits certain populations particularly hard – specifically, the elderly, chronically ill, and uninsured, who rely on hospitals for both emergency care and specialized medical services not available at your local doctor's office, such as an MRI examination or dialysis.

***Increasing the burden on other hospitals strains the entire region's health services capacity***

Even if there are other hospitals nearby, when one closes it places a severe burden on the others. Suddenly the remaining hospitals have to take up the slack for the hospital that closed. This places a huge strain on already overcrowded emergency rooms and on overworked and understaffed hospital staff. This added burden can push those remaining hospitals closer to the brink of closure themselves.

Several factors have helped to create a hospital crisis in many parts of the country: inadequate Medicare and Medicaid reimbursement rates; managed care red tape;, an aging population with greater medical needs; higher use of emergency rooms by the uninsured; and a nationwide nurse shortage. Community hospitals (i.e., non-teaching/academic hospitals) in particular are at great risk of closure in today's health care marketplace. Many have lost patients to more technologically advanced teaching hospitals, even though community hospitals often provide equal quality care. In addition to full hospital closures, "partial closures" (where a hospital closes only certain clinics or stops providing certain services) are adding to the hospital crisis. A partial closure can have as devastating an effect as a full closure on patients who need those services.

# *II. Organizing in the Face of a Hospital Closure*

## *"Don't Mourn, Organize" – Joe Hill, historic labor organizer*

Regardless of whether or not your state has an essential services law, your response to the announcement of a closure will be virtually the same. We've included details about Massachusetts' law and the process it mandates in section III as a sample "roadmap," but it is merely a guide. Fighting to preserve hospital services is a matter of aggressive community organizing. Not even the best law can save a hospital from closing unless there's vocal and indignant community opposition, whereas creative and forceful organizing can save hospital services even without a law on the books. It's all about people power.

This section is based on our experiences in working with the Coalition to Save Waltham Hospital and other organizations that fought to keep Waltham Hospital in Waltham, Massachusetts open after CareGroup, the former owner, announced in early 2002 that it would be closing. The community fought a courageous battle to keep Waltham Hospital open, and succeeded in getting CareGroup to transfer ownership to a local developer and control to a new Board of Trustees. Sadly, the Hospital closed a year later, in July 2003. But the organizing campaign succeeded in keeping it open for a full additional year and enabled other providers and institutions in the area to step in to replace some of the services that were lost.

We learned a great deal from that campaign, both about what was done right and what could have been done even better. We offer those lessons to you in the hopes that they will help you organize against such a closure in your community. We recognize that each situation is different and that what worked in Waltham might be different than what works for you. Nonetheless, there are some steps and guidelines that apply in any anti-closure campaign.

### *General thoughts on organizing a campaign*

In writing this manual, "we hold these truths to be self-evident":

- **The Right to Participate**: That individuals and communities have a right to participate directly, not just through elected representatives, in the decisions that affect their health and well-being;

- **Accountability**: That such direct civic involvement makes public entities accountable, strengthens democracy and produces better decisions about public health and safety; and

- **Direct Grassroots Involvement**: That advocates must directly involve the people affected by decisions such as hospital closures, and should not purport to "speak on behalf of" those affected.

### *Make the system work for you: Using the process as a strategic organizing opportunity*

The procedures for closing hospital services reside in the legalistic netherworld of executive agency oversight. The legally required steps in such a process, while "democratic" in appearance, more often than not actually disenfranchise the people affected by a decision such as a hospital closure. A "public hearing" is usually a formality – staff from the state agency sit at a table in a room, community leaders present testimony, community members sit in the audience and clap at the right places, and little becomes of it. The "comments" submitted by leaders and members of the public are often ignored – neither the agency nor the hospital is bound to actually *listen* to those comments or to make changes based on them – they just have to receive them.

**It is up to YOU to make this process more than a legal formality – to use it as a strategic organizing opportunity that empowers the community and brings pressure to bear on the decision makers.** So how can you ensure not only that the input of your community is actually heeded, but also that the process *increases*, rather than decreases, the power and voice of those affected?

### *Even without a law: Minimum elements of an Essential Services Campaign*

The "Five Steps" in Section III below presume a certain sequence of events. This sequence is based on our experience in Waltham and with the Massachusetts Managed Care Reform Law. However, we think this sequence makes sense strategically, and not just because it happens to be what our law provided for. Regardless of the process that your state law provides for, **there are certain things you need to demand from the public agency that regulates hospitals and closures**:

1. **A public hearing** at which the Hospital presents its reasons for closure as well as its plan for ensuring continued access to the services being lost. The hearing should also give members of the community an opportunity to testify about the impacts of the closure and to challenge the hospital's stated reasons for needing to close or eliminate services. If the closure will affect a large region, more than one hearing may be appropriate. A hearing is a crucial step even if it is on short notice, as it subjects the closure to public scrutiny.

   However, if the agency refuses to hold a hearing, you can organize your own **community forum** to inform the community about the closure and mobilize residents to oppose it**.** Community Catalyst distributes an excellent "Guide to Organizing Community Forums." This guide offers advice that is also useful for organizing around a hearing. *(Resource List, Appendix B, p. 55)*

2. **A determination by the regulating agency of what services are necessary or essential.** Such a finding establishes to which services the hospital must ensure continued access, such as by showing whether or not other area hospitals can meet the need the closed hospital will no longer fulfill.

3. **A written plan by the hospital** of how it will ensure continued access to the necessary services following closure.

4. **Review of the plan** by the regulating agency, resulting in either approval or a request for modifications to the plan.

What if you don't have an "essential services" law like Massachusetts, that requires a public hearing? An official hearing required by law is just one way to make sure that the community's concerns are addressed. In general, there are three principal ways to affect a process like a hospital closure:

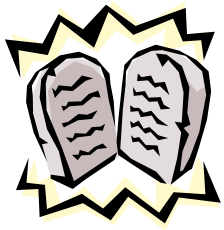
(1) An Administrative Proceeding, like a hearing;
(2) A Court Proceeding, i.e., a lawsuit; and
(3) "The Court of Public Opinion."

Firm public pressure can produce the same result as a law that requires a hearing. The agency that regulates and licenses hospitals (such as the Department of Public Health) most likely has wide-ranging authority over hospitals, including over their closure. Such agencies typically have the authority to convene public hearings on matters affecting public health. The steps listed above need not necessarily be specifically provided for in a law – if you generate sufficient public pressure on the agency, you may be able to force them to require that the hospital go through such a process.

If your department of public health or equivalent agency refuses to go through this process, other public authorities may be more susceptible to persuasion or pressure. A city council, individual state legislator or a committee of your state legislature (such as a Committee on Health Care) could also convene such a hearing, make a determination on essential services, and request a written plan from the hospital. Even if such officials do not technically have the authority to *require* a hospital to appear at a public hearing or submit a written plan, a hospital would be hard pressed to ignore such a request. This is particularly true if you have succeeded in making the closure an issue in the media, or if the owner of the hospital also owns other hospitals in your state that receive public funding. Finally, if you are unable to convince or force any public agency to hold a public hearing, you can **organize and hold a public hearing yourself.**

Although it doesn't have an official government "Stamp of Approval," a well-organized, well-publicized hearing can have the same effect: shaming the hospital, and perhaps also the public agency that refused to hold its own hearing, as well as generating public pressure and media attention to force them to address the community's concerns.

***Guiding principles of a campaign***



In addition to the steps below, keep in mind the Midwest Academy's

## *Three Fundamental Principles Of Direct Action*

1. Win concrete improvements in people's lives
2. Give people a sense of their own power
3. Alter the relations of power – between people, the government, and other institutions*

These three principles should serve as goals or criteria for your campaign. **Keep them in mind as you plan each stage and action of your campaign.** For example, in the Waltham Hospital campaign, here's how each principle was fulfilled:

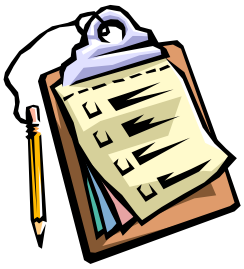
1. ***Win concrete improvements in people's lives*:** Met by keeping the hospital open for an additional year, transferring control to a local Board and helping replace some services after the hospital closed.

2. ***Give people a sense of their own power*:** Met by involving large numbers of Waltham residents in the public hearing and having that presence force the hospital owner to negotiate with the community about the closure.

3. ***Alter the relations of power*:** Achieved by the pressure that the community brought to bear – the decision ultimately was not just between the Department of Public Health and the owner of the Hospital, but also involved the Coalition to Save Waltham Hospital, which demonstrated a significant shift in power dynamics.

* The Midwest Academy (www.midwestacademy.com) trains activists on direct action, organizing, and strategy. It publishes a guide called *Organizing for Social Change*.

# *III. The Five Steps of a Campaign to Save Hospital Services*



**Steps in organizing to save hospital services:**

1. **Information Gathering**
2. **Coalition Building**
3. **Organizing before the Hearing**
4. **Turnout for the Hearing**
5. **Following up on the Hearing**

## *Steps 1 and 2: Information-Gathering and Coalition Building*

These two steps really happen simultaneously. You will need information and assistance from other organizations that will be part of your coalition, and recruiting coalition members will unearth new information. Although we present these two steps separately, they are in fact closely linked.

## Step 1. Gather information


Your local hospital plans to close, or to shut down certain services.

**So what?** Why should anyone care?
Why should it stay open?
Will anyone be hurt if it's shut down?

These are the questions you need to answer at the *beginning* of your campaign. Knowing those answers will help you plan an effective action strategy and will also arm you with the information you need to counter or refute arguments put forth about why the hospital or services should close.

### *Snooping out information*

Getting the information described below will require a bit of detective work. Some places to find this information include:

- **Do you have a law?** How do you know if your state has a law that regulates the process for closing a hospital? If you don't know whether your state has any laws that can help you, you should consult a health care lawyer; the committee of your Legislature that deals with Health Care; the public agency that regulates hospitals (such as the Department of Public Health); the Attorney General's office; and the regional office of the federal

Department of Health and Human Services. (You can find your regional office at *www.hhs.gov*.)

- If your state law requires the hospital to submit a "**Closure Plan**" before the public hearing, a lot of the information you need will be in that document.
- The Hospital's **Annual Report**, if they publish one, may have useful information on the hospital's finances, board of directors and officers, range of services, etc.
- The hospital may be required to submit reports and data regularly to the state agency that licenses and monitors hospitals. (In Massachusetts, that agency is the Department of Public Health). Those reports should be public information. You may have to submit a "Public Records Request" or state-level "Freedom of Information Act Request" to get copies of such reports.
- Your state may have an organization that compiles information on health care institutions and publishes reports on health care in your state. In Massachusetts, there is the Massachusetts Health Data Consortium (*www.mahealthdata.org*).
- If the hospital is a nonprofit, they most likely have to submit annual reports to the Attorney General or your state's Division of Charities.
- For information on the demographics of the towns in the hospital's service area, contact the municipal government of each town. They may also have agencies that can provide information on certain populations in their towns, such as a Council on Elder Affairs or Council on Disability. You can also get local demographic information from the U.S. Census (*www.census.gov*).
- For information on local emergency services, contact your local fire, police and Emergency Medical Services (EMS) departments. Each of these should also be able to direct you to any regional bodies that coordinate local departments that can provide broader regional data on these services.
- The Hospital's department of public affairs can also be a surprisingly helpful source of information. This may vary – if they are bitterly opposing your campaign, they may not be too willing to help your efforts by providing information. If you have a good relationship with any reporters doing stories on the closure, they may be able to get information from the hospital that you wouldn't be able to get on your own.

### *Understand what services are slated to close*

If the entire hospital is to close, what are all the clinics and inpatient and outpatient services at the hospital? You can frequently find a list of the hospital's units, clinics and services on its website. You can also look at its promotional materials (brochures, annual reports, etc.). If just certain units, clinics or services are to close, what treatments, procedures and services does that include? It is *not* enough to know that an orthopedic or cardiac unit is to close – you need to exactly what that means. In particular, are there any highly specialized or unusual treatments or procedures that take place in that unit? Does

that hospital perform a particular procedure or have a particular piece of equipment that isn't available elsewhere in the area?

For example, in Waltham, the hospital had the only inpatient eating disorders program in the region geared specifically toward women. Losing that service would have been extraordinarily damaging to patients all over the state. We were able to recruit additional allies to the campaign because of the impact losing that program would have had. Negotiations to move that program to another institution are currently taking place.

***Who is served by the hospital or the services to be closed?***

You need to know who the patients are – not only are they likely to be the most concerned about the closure, but they may also be a particularly vulnerable population that needs to be especially safeguarded.

You should find out:

- **The total number of admissions** to the hospital or the relevant units each year. If the hospital closes, all those admissions will have to go elsewhere—will other hospitals have the capacity to take up the slack? *In Waltham, we found out that the Emergency Department had 22,300 visits per year. We were able to use that number to show that the other hospitals in the area did not have the capacity to handle that additional patient load. This forced the Department of Public Health to scrutinize the Hospital's closure plan more closely, and helped influence the surrounding hospitals to take steps to increase their capacity.*

- **The breakdown of where the patients come from** – this includes numbers and percentage by town as well as what percentage come from outside the hospital's town and from outside the hospital's "service area" (this can show to what extent the hospital is a necessary resource for the surrounding region). *In Waltham, we learned that almost half the patients came from towns <u>other than</u> Waltham. This demonstrated how important the hospital was to the entire area, not just the town. Again, this spurred the other area hospitals to increase their capacity.*

- **The "payor mix"** – what percentage of patients had their treatments paid for by Medicare, Medicaid, private insurance, the patients themselves and other sources? For patients covered by HMOs or PPOs, are the other local hospitals in those insurers' networks? *In Waltham, this data showed that Medicare was the largest "payor" by far. This strengthened our argument that the hospital was a critical resource for senior citizens. This helped convince the city and other area hospitals to take the problems of seniors' access to care more seriously, such as by expanding transportation to the nearest hospitals.*

- **Data on the demographics of the patients**, if available – race, age, income, immigration status, etc. This can show what groups will be particularly affected by the closure. For instance, if a lot of immigrants use the hospital, will other area

hospitals have the same translation/interpretation services available? If a high percentage of the patients are low-income or elderly, will they be able to pay for transportation to a more distant hospital? *Waltham has a small but significant Spanish-speaking population that had developed a strong relationship with the hospital (and thus appropriate interpretation and other services) through several local churches and social service agencies. Closure of the hospital put that population at risk. A health center in a neighboring community has plans to open a satellite center in Waltham, which will help ensure access for this vulnerable population.*

**Where do you find this information?** In Waltham, the Coalition got most of this information from reports the Hospital was required to file with the Massachusetts **Division of Health Care Finance and Policy**. Many states have parallel agencies, often called **Hospital Rate Setting Commissions** or something similar. State laws frequently require hospitals to report such data on a regular basis.

***What is the health status and level of need of the community?***

You need to show what effect the closure will have on the community in which the hospital is located, not just on the patients who have already used the hospital. Most families in the area will need the hospital at some point. What needs do they have that will potentially go unmet?

- **Data on the demographics of the towns** in the hospital's service area, race, age, income, immigration status – this helps illustrate the impact of the closure, as discussed above.

- Are there significant populations of **vulnerable groups**?

  - Elderly residents (and are there elderly housing developments?)

  - Disabled residents

  - Immigrants

  - Children

  - Uninsured and underinsured people

  What effect will the closure have on these groups? Where will they get care? Will the closure increase the burden on community health centers and other community institutions?

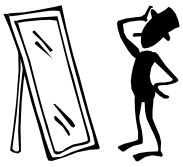
- Are there other **unique or particular health needs** in your community? (such as industrial facilities that might need a nearby hospital to handle emergencies, higher incidence of certain illnesses, significant environmental health hazards

increasing the medical needs of residents, etc.) *For example, in certain neighborhoods in Boston, the incidence rate of asthma is up to 5 times greater than the rest of the state. Without programs and clinics specializing in treatment of respiratory conditions, these neighborhoods would suffer greatly.*

- How many town residents are **employed** by the hospital (everything from surgeons to custodians)? How many will lose their jobs as a result of the closure?

- **What community benefits** does the hospital supply? How much free care do they provide? Do they have free clinics at the hospital or in the community? Do they provide other services to the community, such as free flu shots to local seniors, health condition screenings (blood pressure, etc.), interpreter services, or contribution of hospital staff time to health clinics? What effect would losing those community benefits have on the health status of the community? Many states have laws that require hospitals to submit annual reports of the health needs of their communities, and/or the community benefits the hospital supplies. Such reports are normally public records which you are entitled to see. Community Catalyst has a state-by-state list of such laws, what agency oversees them, and what hospitals are required to do. (*http://www.communitycatalyst.org/acrobat/compendium.pdf.*)

***Ask yourself a hard question: Will your community really use the hospital if it stays open?***



Nobody likes the idea of a community hospital closing, especially one that has been around for a long time and is an established institution in the community. But nostalgia is not enough to sustain a viable hospital. In gathering all the information on who uses the hospital, what services are offered, etc., you must take a long, hard look at the hospital and your community. Will you and the residents of your community really use the hospital? Or will people go elsewhere for their care? Declining patient volume can be an indicator that people are voting with their feet, whether for good or bad reasons. If you fight to keep the hospital open, and then no one uses it, it will close eventually, and you might not be doing anyone any favors by prolonging the inevitable. *In Waltham, the hospital continued to lose patients even after it was saved and kept open. Many people were going to more "prestigious" teaching hospitals in Boston, and others feared that the hospital would still close and so didn't use it. Eventually, patient volume just got too low to keep it open.*

**If people aren't currently using the hospital, can that be changed?** Can creative and aggressive marketing woo back patients who have gone elsewhere? What advantages of the hospital can you promote? (Such as high quality, compassionate care close to home) If you succeed in keeping the hospital open, are you willing to stick around and help make sure it succeeds? If not, you should think seriously about whether you should be campaigning to keep it open. Don't forget the "community" in community hospital – it's the entire community's responsibility to make the hospital viable.

**If people won't use the hospital:** If you conclude that the community won't actually use the hospital even if it stays open, that doesn't mean you should just accept the closure without a fight. Instead, your campaign can focus on calling attention the health needs of the community that will go unmet after the closure, and what can be done to meet them. *For instance, in Waltham, when it became clear in 2003 that the hospital was definitely going to close, activists focused instead on replacing as many of the services to be lost as possible, such as with an Urgent Care Center, community health center, relocation of specialty programs such as the Eating Disorders Program, and increasing capacity at and transportation to the other area hospitals.*

***What is the status of local emergency services and other local hospitals?***

Your local police department, fire department, Emergency Medical Services, and public health department will no doubt be put under additional pressure if a local hospital or particular services close. You should find out:

- Data on current usage of **local emergency services:** How many medical/emergency calls do local police/fire/EMS respond to each year? What percentage is taken to the hospital slated to close? You can get this information from your local police, fire and EMS departments.

- **Location and travel times** to the nearest hospitals: How much longer will it take to get to the other nearest hospitals than it currently takes to get to the hospital to be closed? In an emergency situation, even a few extra minutes can mean life or death. *In Waltham, we had community members drive to each of the nearest hospitals during rush hour and record the time it took to get there. This information showed that the nearest hospitals were still too far away in case of an emergency – that the additional minutes it took to get to them would indeed mean the different between life and death for, say, patients having a heart attack. The City of Waltham, the regional EMS council and the area hospitals are now looking at how to ensure adequate ambulance services.*

    - What transportation services (taxis, shuttle services for elderly and disabled, public transit) are available to those without cars? Do those services go to the other local hospitals? How long does it take? How frequently do they run? What is the cost?

- **The total number of annual admissions** to the other local hospitals and their occupancy rates (the number of patient-days actually used divided by the number of total available patient-days). This will demonstrate whether other area hospitals actually have the necessary capacity to absorb all the admissions that won't be taken by the closed hospital.

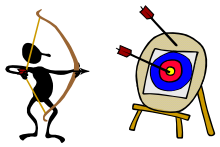
- **Emergency Department "Diversion" statistics** for the other local hospitals: How frequently and for how long were those hospitals "on diversion," i.e., they had to send ambulances elsewhere because their emergency departments were at

capacity. *In Waltham, we showed that the region had the state's highest rates of diversion. This bolstered our argument that the other hospitals wouldn't be able to handle the emergency visits that used to go to Waltham Hospital and helped push the area hospitals to address their emergency department capacity.*

- **Other impacts:** Speak with your local fire department, police department, Emergency Medical Services department, Council on Aging, local physicians and public health department to get information on other impacts of the hospital closure. You will learn about impacts that you would not otherwise have even realized existed. *In Waltham, we learned from a local church serving the Latino community that it hosted a monthly free care clinic at the church, run by medical staff from the hospital. That clinic was central to building a strong relationship between the hospital and Waltham's Latino community, and served a vital outreach function to an underserved population. The plans for a new community health center will help fill the gap left by the closure of this clinic.*

## Step 2. Coalition-Building: Herding Cats in a Thunderstorm

A campaign to preserve hospital services requires cooperation among a wide variety of groups with different interests. You will have to balance the interests, agendas and even egos of the various groups that need to be in your coalition. Coalitions have a tendency to take on a life of their own and to stray from the purpose for which they were created. It is wise to organize your coalition around a simple, clearly articulated mission, such as **"Keep Waltham Hospital open to meet the health needs of the community, particularly vulnerable people."** Once you've won the battle to keep your hospital open, you may want to keep the coalition together to work on other issues of health care access. That's great—but for now, keep your eyes on the (immediate) prize.



***Groups to recruit for your coalition***

*Municipal and elected officials*

- ✓ Mayor
- ✓ City/town councilors/selectmen/aldermen
- ✓ Board of Health
- ✓ Fire/police/EMS departments
- ✓ Council on Aging
- ✓ Council on Disability
- ✓ State and federal legislators whose districts include any portion of the hospital's service area

*Community and nonprofit organizations*

- ✓ Community health centers and clinics
- ✓ Neighborhood associations
- ✓ Tenants groups (particularly for public housing or elderly housing developments)

- ✓ Religious congregations and clergy (particularly those who have members in vulnerable populations—elderly, immigrant, low-income, disabled, etc.)
- ✓ Civic and service organizations – League of Women Voters, Rotary, Kiwanis, community centers (YMCA/YWCA, VFW, Boys & Girls Clubs, etc.).
- ✓ Chamber of Commerce, local businesses, statewide small business organizations
- ✓ Community Development Corporations (CDCs)
- ✓ Human service providers, homeless shelters
- ✓ Legal services organizations
- ✓ Local newspapers, radio stations, cable access programmers

*Regional or statewide organizations*

- ✓ Senior citizen action groups (such as Gray Panthers, AARP)
- ✓ Disability rights groups
- ✓ Immigrant rights and civil rights groups
- ✓ Health care access and advocacy organizations
- ✓ Public health organizations
- ✓ Labor unions (particularly those unions who represent staff at the hospitals, SEIU, AFSCME, state AFL-CIO)
- ✓ Gay, Lesbian, Bisexual, Transgender rights organizations
- ✓ Professional organizations of medical personnel (Medical Societies, Nurses Associations)
- ✓ Statewide or regional community organizations (ACORN, Citizen Action, Industrial Areas Foundation affiliates)
- ✓ Advocacy/Service Organizations for particular conditions (American Cancer Society, American Lung Association, National Alliance for the Mentally Ill, etc.)
- ✓ State Hospital Associations

An enormous amount has been written about the process of coalition building. This guide is not intended to instruct you on the process of building a community coalition to preserve hospital services. Community Catalyst has a very useful guide called **"Strength in Numbers: A Guide to Building Community Coalitions."** *(Resource List, Appendix B, p.55)* Your coalition may be different than traditional community coalitions – if you are forming with the express goal of preserving hospital services, your coalition will have a defined, time-limited goal. Your coalition may stay together beyond that goal to work on other health issues, or it may dissolve. If you already have a local coalition that addresses health issues in your community, then you're ahead of the game.

**There are a number of things you'll need to address in forming a coalition to preserve hospital services.** Some of them may be hard to achieve when you're in the midst of the immediate crisis of trying to prevent a hospital from closing. Nonetheless, you should keep them in mind and do the best you can to achieve them. They are particularly important if you want your coalition to continue working together after the crisis has passed**:**

- ✓ **Keep it grassroots and democratic:** Coalitions, like any organization, can easily fall into a traditional top-down, non-participatory model. This will hamper your

campaign. Remember the Midwest Academy principles of "Giving People a Sense of Their Own Power" and "Altering the Relations of Power."

- Make sure that the decision-making power in your coalition doesn't concentrate in those who are most vocal, most well-known, or who are in the "traditionally" powerful positions. For instance, if your coalition includes doctors, nurses and other hospital staff, try to make sure the doctors don't run the whole show. Similarly, if there are elected officials, they have a tendency to want to be in charge or to always add their two cents. Your coalition will be much more successful if you insist on from the get-go democratic, participatory processes and if you value the contribution of everyone involved.

✓ **Make it diverse:** It's important to make sure that your coalition represents the diversity of your community – its racial and ethnic diversity, different age and income groups, various neighborhoods, etc. Those who are most impacted by a hospital closure tend to be those groups with the least power in your community and in society generally, particularly the elderly, low-income neighborhoods, communities of color and immigrant communities. It takes hard work to make sure that your coalition doesn't reproduce the very same power imbalances that make those groups more vulnerable and powerless to begin with. To build a successful diverse, multicultural coalition, you have to start early, build relationships and trust, and share power and responsibility. Several things can make this easier:

- **Don't "tokenize":** Make sure that any group you invite to join your coalition is being invited to be a full participant – involve everyone in the work of the group, not just those "public" events where you need to put a diverse "face" on the coalition.

- **Make your meetings accessible:** Arrange for child care, translation, transportation, wheelchair-accessibility or whatever is necessary to enable people with different needs to attend your meetings. Have meetings at a time of day when the greatest number of people can make it—usually not during the workday.

- **Don't assume:** Don't assume that you know the needs and problems of a particular group or community. Ask, listen, and incorporate what you learn into the coalition's work and plans.

- **Balance power and participation in meetings:** Groups and individuals with more power have a tendency to dominate in meetings. Make sure that everyone's participation is invited and encouraged. You can do this by limiting the number of comments any individual can make, or by going around the room to get input or feedback from each person present, and the

like. Spreading participation and responsibilities around also gives others the opportunity to build leadership skills.

- ✓ **Will your coalition be open to both individuals and organizations?** If so, how will you balance the participation of both?

- ✓ **What will be your decision-making process?** Will it be a formal process, with requirements for what constitutes a quorum and what percentage of votes is necessary for a decision? Who gets a "vote?" If both individuals and organizations are members of your coalition, will they have equal votes? Will you use formal rules of procedure such as Robert's Rules of Order, or operate more informally? If you decide to use consensus decision-making, are the participants familiar with the consensus process, or do you need to offer a training workshop on it?

- ✓ **How the work will be shared?** Will you expect each organization to commit to certain tasks? If so, who will be in charge of making sure they follow through on those tasks? Tension can arise if certain members feel that they are doing all the work.

    - ➢ **Be clear about expectations.** Ask members to only commit to what they can actually do.

- ✓ **Who will pay expenses?** Even a shoestring coalition still needs to pay for the shoestring. Be clear and upfront about who will be responsible for these expenses.

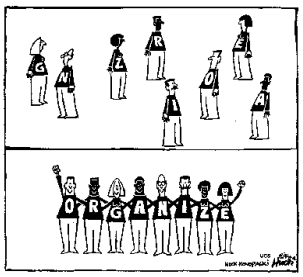
- ✓ **Who will take the credit?** This is a thorn in the side of many a coalition. Members of coalitions frequently feel that another organization is taking an unfair share of the credit. You may want to decide to only use the name of the coalition in your materials and actions, or to always include a full list of member organizations so no one is left out. Issues like "whose letterhead will the press release go on" can take on a great deal of significance.

    - ➢ **Be clear about "identity.**" At public events (press conferences, the public hearing, etc.) will representatives of the coalition identify themselves only as affiliated with the coalition, or also with their individual organization?

- ✓ **Who will coordinate the work of the coalition?** Will it be an organization that's doing the primary work of pulling together the coalition? Will it be a "committee" of coalition member representatives? Or will the coalition have staff?

- ✓ **Do you need to form a legal entity,** such as a 501(c)(3) non-profit? Factors in deciding this include: will you be accepting donations? Do you anticipate a role for the coalition beyond this campaign? Will you need insurance? Your state or local Bar Association may have a program that provides community groups with free legal assistance on these issues.

## Step 3. Organizing Before the Hearing




### GOALS:

- **Mobilize your Allies for the Hearing**
- **Arouse Community Anger**
- **Attract the Attention of the Media**

It is likely that your community will be aware of the closure even without your organizing. A hospital closure is significant enough that the media will most likely report on it anyway. Your task is to change the message reaching the public from **"our hospital is closing, that's too bad, there's nothing we can do"** to **"the closure is not inevitable and we have to FIGHT to keep it open."** You will have at least several weeks between the time the public hearing is announced and the hearing itself. You have your job cut out for you. If you don't have a law requiring a public hearing, your first task will be to organize the community to demand one. The steps described below apply equally to demanding a hearing as to preparing for one. In fact, these two goals can be addressed simultaneously.

The public hearing is not the time to educate the community about the danger faced by the hospital closure. **That education must occur long before the hearing**. Here are some steps towards achieving that and reaching the three goals above:

**Public Forums:** Hold one or more "public forums" or "speakouts" at which coalition representatives can present information about the impact of the proposed closure. Invite other community leaders to speak at the forums—doctors, nurses, elected officials, clergy, etc. Have an "open mike" section of the agenda for attendees to speak out about how they and their families will be affected (this will help you identify powerful speakers to testify at the actual hearing). Such public forums create essential momentum for the big push at the public hearing.

**Letters to the Editor/Newspaper Articles**: Have coalition members write "letters to the editor" to local and regional newspapers. In many communities, the local paper is small enough that you can easily meet with a reporter or editor from the paper and ask them to do a story about the closure and your coalition. They may even give you free ad space to publicize your forums and the public hearing. Don't rely on the minimal publicizing of the public hearing that your state agency will do. YOU need to make sure that the turnout is high.

**Sermons:** Prepare a "sermon sheet" for local clergy, in which you ask them to talk about the hospital closure in their weekly sermon, and give them "talking points" on the issues (including, of course, a call for people to attend the public hearing!).

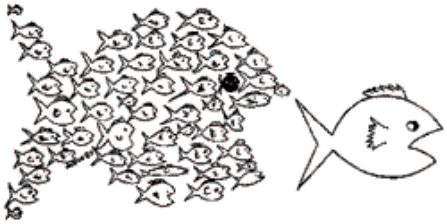
**City Council meetings**: If your city council/board of aldermen meets regularly, ask to have the issue of the closure put on the agenda. Discussion of it at a city council meeting

can encourage the councilors to get actively involved and gives the campaign credibility and a higher profile.

**Flyers**: Create a simple eye-catching flyer alerting people to the proposed closure and the public hearing. Post it everywhere possible, and have coalition members hand it out at community events and locations with high foot traffic (supermarkets, post offices, etc.). Make sure there's a contact number for people to get involved. *(Appendix A, Exhibit B, p.41)*

**Hearing submission letters**: Write a "form letter" for individuals to sign expressing opposition to the closure, with a space for them to include their own comments or experiences. Distribute these to organizations in your coalition. Have them get their members to sign and complete letters. Gather these to submit to the public agency at the hearing. Senior housing, public housing, and senior and community centers are all good places to get large numbers of letters signed quickly. *This can be very powerful – at the Waltham hearing, we submitted to the Department of Public Health over 300 letters from seniors. It greatly enhanced the testimony presented and also added a significant and documented bloc of voices to the official record which the DPH was supposed to consider in granting or denying its approval of the closure. (Appendix A, Exhibit C, p.42)*

## Step 4. Organizing for the Hearing



**GOALS:**

- **Large turnout with good visuals**
- **Coordinate testimony**
- **Get press coverage**

***Turnout:***

- Find out **how many seats** are in the hearing room. Set a goal of turning out that number plus 30% more (not everyone who says they will attend will do so, but that there will be others who attend of their own accord). A full room is critical to the impression you create!

- Get each member of your coalition to commit in bringing a specific number of people.

- Arrange **transportation** for groups that need it - particularly residents of elderly housing developments (this is easy to do since they're clustered in one location).

- Appoint a turnout coordinator to check in every few days with each member organization to see how they're doing on meeting their turnout goal.

- Have member organizations make **reminder calls to *everyone*** who said they'd attend the night before the hearing.

***Visuals:***

- **Make stickers or buttons** with a short message (Save X Hospital!) plus the name of your coalition to distribute as people walk into the public hearing. Make sure they're big enough to read in photographs. Make more than you think you'll need.

- **Make signs and placards** for people to hold up at the hearing. "Sign-making parties" are a good way to generate momentum, build your group, and boost morale. Keep the messages simple and short. Make the letters big and dark so that cameras can pick them up easily. Include the name of your coalition. Don't attach the signs to sticks or poles, as many public facilities no longer permit them for security reasons.

***Press coverage:***

- Get local press contacts from each of the coalition's member organizations. Many of them will already have well-established relationships with local reporters – utilize those relationships. Don't reinvent the wheel.

- **Send a press advisory** to your list of media contacts the afternoon before the event. Call each media contact individually and see if they plan to attend or to send someone.

- **Prepare "press packets"** to distribute to reporters who attend the hearing. Designate someone as the Press Coordinator. That person will make sure that each media representative who attends gets a press packet, and will get contact information from each of them for follow-up calls. Your press packet should include copies of the testimony to be delivered by the coalition's representatives, any additional material you're submitting to the public agency, and a press release summarizing your testimony and including some catchy quotations that the press can use.

***Accessibility of the Hearing:***

- If you will need any of the following, request it from the public agency well in advance:

  - **Sign language interpretation**

  - **Foreign language interpretation**

  - **Make sure the facility is wheelchair-accessible**, in particular the area from which people will testify (i.e. if the microphone is up any stairs, that's a problem)

***Preparing your testimony:***

- **Develop your message**: No doubt you will have a lot to say about the planned closure and what the hospital has to say about continued access to those services. By all means, include all of that in your written testimony that you will submit at the hearing. However, for purposes of your *spoken* testimony, you will need to pick and choose, and develop a concise, punchy message.

  - **Anticipate the hospital's testimony**: The hearing will probably begin with the hospital making a presentation about why they need to close, at what alternate sites patients will access care, and what the impact of the closure will be. Come up with a response to what the hospital is likely to say—for example, if they will say that patients can get the same services at Hospital X 10 miles away, be prepared to present information on that hospital's capacity and travel time.

  - **Pick three main points**: Decide what are the three most important issues you want to raise. Have the coalition's designated testifiers (see below) focus on those three points in your testimony. Make those three points the focus of your press release. Advise the groups in your coalition who plan to have individuals testify that they should drive home those three points as well.

- **Know how many copies you need to bring with you.** Ask the public agency how many representatives it will be sending. Bring enough for each of them, plus several extra.

- **Prepare "coalition testimony" and select designated representatives.** The public hearing is an opportunity to organize lots of people to testify, and you should encourage as many members of the public as possible to do so. However, your coalition wants to deliver a clear and coherent message *as a coalition*. You should select a small handful of coalition members who will testify on behalf of the coalition itself. *In Waltham, we had a local minister, the director of the Council on Elder Affairs and a disability rights advocate testify for the Coalition. (Appendix A, Exhibit D, pp. 43-45)*

- **Ask for time at the beginning**: If it's well attended, your public hearing will last at least several hours. You should ask the agency holding the hearing to let the coalition's representatives testify at the beginning. (They almost always reserve spots at the beginning for elected officials, and it's easy enough to reserve a few spots for your group as well).

**Tips on testifying:**

- **K.I.S.S**: Keep It Short and Simple. You may be given a time limit for your testimony. Even if you aren't, keep it brief and avoid using legal jargon or acronyms.

- **Speak loudly, slowly and clearly, and project your voice.** Practice your testimony beforehand several times.

- **Address the audience as well as the agency:** This is a small but important shift in emphasis. If possible, turn to face the audience as you speak. Treat this as the *public* hearing it should be—**don't think of yourself as pleading with the agency for their mercy**—instead treat this as a public forum in which members of the community are speaking out on an issue of grave concern and demanding that their public officials do what they should.

## Step 5. Post-Hearing Follow-up

Your work does not end after the hearing! In Massachusetts, the public hearing sets in motion a review process by the Department of Public Health. The steps in that process provide critical opportunities for you to provide a community perspective and to further publicize the effects that a closure would have. If you are able to avert the closure, your coalition and the community still have a role to play in ensuring that the hospital is able to survive into the future.

***Press follow-up:***

Compare your list of press contacts to the list of which press actually attended the hearing. Deliver press packets by the next day to those reporters who did not attend the hearing. Offer them the opportunity to interview the coalition representatives.

- If the hospital said something unexpected at the hearing that your representatives were not able to respond to on the spot, supplement your testimony with a statement containing your refutation. If it's sufficiently important, send it to all the media on your list, including those that attended the hearing.

- Check all the media on your contact list for articles or reports on the hearing. Clip articles and record broadcast reports.

- Send a letter to the editor and to the individual reporter if any article or press report misstated something that was said at the hearing (by your representatives or by anyone else), or failed to challenge any questionable assertions made by the hospital.

### *Hearing follow-up*

- Find out if the agency that held the hearing will accept written testimony after the hearing, and for how long. If they will, you can use this opportunity to refute any points that the hospital raised at the hearing that weren't addressed in your testimony. If you had community members sign petitions or "form letters," you can also use this as an opportunity to submit additional ones.

### *Post-hearing review*

- In Massachusetts, the Department of Public Health (DPH) has 15 days after the hearing to issue a report detailing what services of the hospital it deems "essential." *In Waltham, the DPH found that the entire hospital was "essential"! The DPH demanded that the hospital submit a very detailed closure plan that would detail how patients would get access to all inpatient and outpatient services elsewhere. (Appendix A, Exhibit E, pp. 46-49) The hospital worked closely with the other area hospitals, the owner of the hospital site, a local community health center, and the City to begin planning for an Urgent Care Center, a satellite community health center, shuttle bus service to other hospitals and other measures to ensure continued access to a number of vital services.*

  Even if your state law doesn't have an exactly parallel provision, it is likely that the public agency will issue some kind of report or findings based on what was said at the public hearing. You can do several things:

  - Give the agency your own proposals for what should be in the report. You can even give them a draft that they could simply adopt. *(Appendix A, Exhibit E, pp.46-49)* Some components to include are:

    - A detailed protocol on how patients will access the services at other sites, as well as information on where such sites are, what their capacity is, and why the hospital thinks they can handle the increased demand created by the closure.

    - Update information on utilization of services before the closure, including admissions and discharges, occupancy rates, length of stay, patient origin and payor mix.

    - Travel times to the alternate sites at different times of day (e.g. middle of the night vs. rush hour), and assessment of the community's transportation needs.

  - When the report is released, send a response to the agency and your press list. (*See http://www.hla-inc.org/public/CareGroupplancomments402.doc for Health Law Advocates' response to the draft closure plan for Waltham Hospital. )*

- If the agency requires the hospital to submit a plan for ensuring continued access to the services to be closed, scrutinize that plan carefully and submit your own written response to it. This is another chance to specify the effects that the closure will have on the community, particularly its most vulnerable residents. If the hospital's plan says that patients can get adequate access at Hospital Z 10 miles away, provide information about travel times, capacity at Hospital Z, etc. You can also suggest follow-up questions or information for the agency to request from the hospital. Again, send copies of any written materials you submit to your press contacts to keep them informed and to keep public attention focused on the issue.

***Keep the issue alive***

Even if your hospital closes, you will have other opportunities to raise the issues that the closure presented and to exert public pressure to make sure that your community's needs are met. Some examples include:

- **Continued access to services:** If the hospital claimed that other nearby hospitals would be able to provide adequate access to the services being lost, you can monitor whether those other hospitals are in fact doing so. If they made any kind of commitment to take up the slack, you can pressure them to do better. Even if they didn't, documenting that there aren't sufficient resources to meet those unmet needs can help in efforts to expand health services in your area. You can work to fill gaps left by the closure with other types of providers – such as community health centers, urgent care centers, satellite locations of other hospitals or clinics, and individual physician practices.

- **Make it a campaign issue:** If you were unsatisfied with how local or state elected officials responded to your campaign and your demands, you can raise those issues when those officials are up for reelection. You can pressure these officials, for example, to allocate state money to assist hospitals at risk for closure, to increase state Medicaid reimbursement rates for services provided by hospitals, or to require hospitals to provide their fair share of free care and community benefits.

- **Take it to the State House:** If the lack of an essential services law or certain features in such a law hampered your ability to save the services your hospital provided, get involved in efforts to strengthen state laws and regulations governing hospital closures. Even your negative experience may help prevent another community from losing its hospital.

- **Get involved in regional health planning:** Your campaign will no doubt have raised the issue of the health needs of your community and whether they are being met. Regardless of whether your hospital stays open or closes, the work your coalition did in the campaign to keep it open forms a great basis for a longer-term effort to document the community's health needs and work to

meet those needs. You may decide to turn your coalition into a permanent regional health planning campaign.

- **Help make your hospital successful:** As we learned in Waltham, just because you avert the immediate threat of an announced closure doesn't mean that your hospital is out of the woods. A hospital and its community exist in a delicate symbiotic relationship. If patients stop using the hospital, it will have less and less revenue to stay open. Staff will leave, its reputation will diminish, and more patients will abandon it, in an ever-widening downward cycle that eventually will cause it to close. If you succeed in keeping the hospital open, you have an ongoing responsibility to help make it a success so it can *stay* open. There are many ways your coalition can do this, from helping to "market" the hospital to potential patients, to seeking representation on hospital's Board, to building partnerships between the hospital and community institutions – churches, schools, and senior centers (such as through offsite screening clinics, health fairs, etc.) that will bring patients to the hospital.

# *III. Massachusetts' Essential Services Law and Regulations*

The process described in the previous sections closely follows that laid out in Massachusetts' Essential Services law, upon which our experience is based. This section describes the main components of that law. Regardless of whether your state has a similar law, this section provides a guide to what an essential services law can look like and include. This can be particularly useful in designing an essential services law for in your state.

***Welcome to Waltham***

Waltham, Massachusetts is a middle-class and working-class suburb of Boston with just under 60,000 residents, a significant percentage of whom are seniors. Waltham was home to **Waltham Hospital**, a community hospital, for over a hundred years. The Hospital faced financial difficulties in recent years as Waltham residents seeking high-tech and specialty care went instead to well-known teaching hospitals only several miles away in Boston. **CareGroup**, which owns a number of hospitals in Greater Boston, acquired Waltham Hospital in 1996. In early 2002, **CareGroup** announced its plans to close the hospital in May 2002. A coalition of local residents and leaders, hospital staff and advocates successfully used the Massachusetts Essential Services law to call attention to the disastrous effects of a closure and to pressure CareGroup to negotiate with the coalition to keep the hospital open. This manual grows out of that campaign.

***Massachusetts Essential Services Law***

In 2000, health care advocates succeeded in passing a significant set of health care reforms in the Massachusetts legislature. **Chapter 141**, known as the Managed Care Reform Law, contained a number of important components. One of these was the **"essential services" law**, Mass. General Laws chapter 111, Section 51G. We include a description of the law and its regulations here to help you understand the steps we took in our campaign to keep open Waltham Hospital. Keep in mind, however, that **the key to winning is public pressure, not regulations.** Even if you don't have a similar law in your state, you can still follow the steps in the previous section and win.

Web links for the full text of this law and the Massachusetts Department of Public Health's regulations on it are included in *Appendix B*. The relevant features of the law are:

**Notice of planned closure and public hearing:** A hospital must inform the Department of Public Health (DPH) in writing of any plans to discontinue any essential health service 90 days in advance. The DPH then must determine whether those services are necessary for preserving access and health status in the service area.

1. The hospital must submit a plan to DPH for ensuring continued access to such services.

2. The DPH must hold a public hearing prior to closure or elimination of essential services.

**Defining Essential Services:** This law also required the DPH to define "essential health services" in regulations. The Department put that definition in the Code of Massachusetts Regulations at 105 CMR 130.020, which is included its entirety in *Appendix B*. The DPH defined "essential health service" very broadly – it said that all treatments and services included in its general definition of "Service" are considered essential, except for a very short list of Excluded Services.

***Overview of Massachusetts Department of Public Health's List of "Essential Services"***

Medical/surgical service & Intensive Care Unit (ICU)
Coronary Care Unit, Burn Unit
Pediatric, maternal and neonatal units
Psychiatric & Substance Abuse Services
Chronic Dialysis Service
Rehabilitation Service
Ambulatory Care Services
Emergency Services
Hospice Services
Outpatient dental services
Outpatient psychiatric/mental health services
Outpatient reproductive health services

*Excluded Services (i.e. Nonessential)*
Skilled nursing facility service
Intermediate care facility service
Cardiac catheterization service
Chronic care service
Hematopoietic Progenitor/Stem Cell services

**Note:** In exceptional circumstances, the DPH can find that an otherwise excluded service is "necessary for preserving access and health status of patients in the hospital's service area," i.e., essential.

Each of these services and others considered "essential" are defined and described in greater detail in the DPH's regulations (see the definition of "Service" in 105 CMR 130.020 in *Appendix B*).

## *Steps in the Hospital Closure Process in Massachusetts*

1. Hospital notice to Department of Public Health (DPH) 90 days before closure
2. DPH schedules hearing 60 days before closure
3. DPH publicizes hearing 21 days before hearing
4. Public hearing
5. DPH Determination within 15 days of hearing
6. Hospital submits plan within 15 days of determination (public may comment)
7. DPH reviews plan within 10 days and responds, may approve
8. Hospital responds to DPH comments
9. DPH Post-Closure Report

***Steps in the Massachusetts Essential Services Law Process***

This is a general overview of the steps required by MA law and regulations. There are exceptions and additional provisions. See the regulations in *Appendix B* for full details.

1. **Hospital notifies DPH in writing** of plans to close *any* service (not just those defined as "essential") provided by the hospital 90 days before the planned closure.

    a. The notice must include a variety of information about the service, including current utilization rates, anticipated impact of closure, date set for closure, and a list of health care coalitions and community groups known to the hospital.

    b. The hospital must also send a copy of the notice to any existing coalitions and health advocacy groups.

2. **DPH schedules a public hearing** to be held in the hospital's service area at least 60 days prior to the proposed closure date.

3. **DPH publishes notice in local newspapers** at least 21 days prior to the hearing.

4. **Public Hearing is held**: Hospital describes services to be closed and plans for alternate access to those services. Members of the public can present testimony and comments.

5. **DPH determines within 15 days of the hearing** whether the services to be closed are necessary for preserving access and health status in the hospital's service area.
6. If the services are deemed necessary, **the hospital submits a plan within 15 days** for ensuring continued access to the necessary services following closure.

7. **DPH reviews the plan within 10 days** and sends the hospital written approval or written comments. The hospital responds to any comments.

8. **What if the plan doesn't assure continued access?** A major gap in the Massachusetts essential services scheme is that the DPH has no enforcement authority to ensure continued access. Its only power is to "review" the hospital's closure plan and plan for continued access. It is unclear what would happen if the Department concluded that the plan was inadequate. The Department doesn't appear to have the power to prohibit the hospital from closing the services.

9. **Post-closure report**: The DPH prepares a "post-closure" report within one year that evaluates whether access has been preserved.

### *Lessons learned from Massachusetts' Essential Services Law*

If the immediate crisis of a threatened closure has passed, or if you're planning ahead in anticipation of future closures, here are a few things to keep in mind as you seek to have your state pass an "essential services" law:

#### *The devil is in the details: Good implementation as the key to an effective law*

Due in large part to organizing and lobbying by advocates such as Health Care For All, the DPH defined "essential services" very broadly. The breadth of the DPH's definition of "essential health services" demonstrates that the implementation and interpretation of an essential services law is as important as the language of that law. The DPH could have defined "essential health services" very narrowly, and thus seriously compromised the usefulness of the law. But by defining "essential health services" to include *almost everything that hospitals do*, the DPH gave the law a very wide-ranging effect and all but invited advocates to use the law creatively. This is an important lesson for those seeking an essential services law in their own states.

#### *Does it have teeth? Enforcement power is key at the end of the day*

Massachusetts provides a multi-step process to protect access to services in the face of a closure. But what if the closure plan is insufficient? Under the Massachusetts law, the DPH has no power to *force* the hospital to keep improving its closure plan or to remain open. The DPH's only power, once the closure plan is submitted, is to comment on or approve it and ask the hospital to respond. In the end, the hospital can still close, regardless of what the DPH says. This severely undercuts the power of the DPH to prevent loss of access to services – since ultimately they can't force the hospital to do anything, a recalcitrant hospital could play along with the earlier steps in the process, submit an inadequate closure plan that fails to provide for continued access to the closing services, and close up shop. All the process would have done is generate some publicity and slow things down a bit. With good organizing, that process can result in the hospital being kept open. But what if it doesn't?

If you're *seeking* an essential services law in your state, try to secure some type of enforcement power for your public agency at the end of the closure process. This might take any number of forms—right now, such enforcement power is virtually unknown, so we are looking to other states to come up with creative models of such powers as they implement

this type of law. The Massachusetts DPH regulations on *nursing home* closures offer one model: if the DPH finds that a nursing home's plan for relocating residents before a closure is inadequate, the DPH can declare that an emergency exists ("a situation or condition which presents imminent danger of death or serious physical harm to patients, including but not limited to imminent or actual abandonment of an occupied facility") and can seek court appointment of a receiver to take over operation (and presumably closure) of the nursing home. See Code of Mass. Regulations at 105 CMR 150.123(D) and Mass. General Laws chapter 111 section 72M. Similarly, an essential services law might give a public agency the power to seek appointment of a receiver if the agency concluded that the hospital's closure plan failed to adequately provide for continued access to essential services.

You might also seek a provision that requires the DPH to investigate the availability and adequacy of health care in the hospital's service area when a hospital submits a notice of intent to close. In Waltham, the closure announcement revealed not only how important the hospital was to Waltham and the surrounding towns, but also just how shaky the ground was that the hospital stood on. Had our Essential Services law required the DPH to investigate those conditions and takes steps to remedy them, that might have helped the hospital to stay open.

# *V. Carry It On: Conclusion and Moving Forward…*

*"Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality, tied in a single garment of destiny."*
*– Martin Luther King, Jr., Letter from a Birmingham Jail*


We hope that the lessons learned from our experience in Massachusetts, fighting to preserve essential health services in the town of Waltham, are useful to you in your local struggle. No doubt you will experience obstacles (and hopefully successes!) that we haven't even anticipated. The movement for universal access to quality and affordable health care is only as strong as the links we create and the lessons we share.

We encourage you to share your experiences with us, to tell us what worked and what didn't work, to impart whatever wisdom you gain in your local fight, so that we can improve this manual and help others learn from what you've learned. Please send us your feedback, your "war stories," and copies of your flyers/testimony/press clippings:

**Health Law Advocates**
**30 Winter Street, Suite 940**
**Boston, MA 02108**
Contact: Alex Sugerman-Brozan
alex@hla-inc.org

**Community Catalyst**
**30 Winter Street, Suite 940**
**Boston, MA 02108**
Contact: Dawn Touzin
touzin@communitycat.org

# *Epilogue: What we learned from Waltham Hospital's closure*


This manual has spent the past 32 pages telling you how to "Keep it Open!" You may wonder where we get the nerve to tell you how to keep a hospital open when Waltham Hospital, upon which this manual is based, ultimately closed.

Despite the fact that Waltham Hospital did eventually close, we still feel the campaign of the Coalition to Save Waltham Hospital was a success. There will be times when no amount of community pressure or organizing can prevent a hospital from closing – if the finances just aren't there, if patient volume is too low, if staff leave in large numbers. However, even in such a situation a community should not just stand on the sidelines while the hospital packs up it tents and goes home. An aggressive campaign can call attention to the health needs of the community and help marshal resources to meet those needs.

When Waltham Hospital announced in Spring 2003 that it was closing (for real) by July 29, 2003, a number of important developments occurred:

- The Joseph Smith Community Health Center, located in Brighton, Massachusetts (just a few miles from Waltham), announced plans to open a satellite center in Waltham. This will be an invaluable source of high-quality affordable primary care for Waltham residents, particularly the elderly and uninsured.

- Newton-Wellesley Hospital, one of the nearby hospitals that will absorb most of the Emergency Room visits that used to go to Waltham Hospital, announced plans to open a 24-hour Urgent Care Center on the former campus of Waltham Hospital. This center will be equipped to handle many of the non-emergency visits that used to show up at Waltham's Emergency Room. Newton-Wellesley also took a number of other steps to expand their capacity to accommodate Waltham patients.

- Newton-Wellesley Hospital and Caritas St. Elizabeth's Medical Center (in Brighton) both began operating a free shuttle bus service from the Waltham Hospital campus to their respective Hospitals. This will help address some of the transportation obstacles faced by Waltham seniors and others with no way to get to these hospitals outside of their community.

None of these plans were in the works or even under discussion when CareGroup announced its planned closure in 2002. Without the sustained pressure of the community and the Coalition's aggressive campaign, Waltham Hospital would have closed in Spring 2002, with nothing additional to replace any of its services. Ultimately, however, the exodus of patients and staff made it impossible for the hospital to stay open.

***What were the successes of the Waltham Hospital campaign?***

- The hospital remained open for more than a year longer than it would have, serving thousands of patients and allowing for a more gradual adjustment to its eventual closure.

- A new, community-oriented Board of Trustees was appointed, giving the community more of a say in the management of the hospital.

- The campaign focused the attention of the media, the public, the legislature and the Department of Public Health on the crises facing community hospitals in Massachusetts, attention which hopefully will help avoid future closures and spur action by the state.

- Hundreds of Waltham residents got a crash course in activism and political mobilization, and gained skills that they can use in hundreds of ways to improve their community.

- The city government of Waltham, state agencies, legislators, private developers, doctors, nurses, community organizations and just regular folks all worked together to save the hospital, forging working relationships that will continue into the future and demonstrating a model of collaborative community problem-solving.

- The campaign set a precedent that a hospital, particularly one affiliated with a large hospital network, cannot just close up shop without seriously addressing how the community's continuing needs will be met.

- The campaign raised the bar on mobilization for DPH public hearings, and forced the DPH to seriously consider the concerns of the people affected by the closure.

We also learned some hard lessons from the Waltham campaign, and there are things we could or should have done differently. Without a crystal ball, we can't say whether they would have made a difference or not in keeping the hospital open. But you should keep these lessons in mind when conducting your own campaigns:

- **Use it or lose it:** While the residents of Waltham wanted the hospital to remain open, many of them didn't actually use the hospital. This was due to several factors:

  - Fears about whether the hospital would really remain open;

  - Patients going to the more prestigious teaching hospitals in Boston, particularly newer residents who didn't have an historic attachment to Waltham Hospital; and

  - Staff departures creating an impression that the hospital was a sinking ship being abandoned by the crew.

Each of these reinforced the others – as patient volume went down, more staff left, causing residents to be even more wary of using the hospital, causing staff to worry about their jobs, in an ever-widening downward spiral.

- **"Out of the frying pan" does not mean "out of the woods":** Averting the immediate crisis of an announced closure is not the end of a campaign. The underlying causes of the closure must be addressed. If patient volume continues to fall, and finances don't improve, the hospital will close eventually. Community coalitions must think creatively and work with the hospital administration to turn the hospital around and ensure it attracts enough patients to be viable. This is particularly true when, like Waltham, a hospital is located in an area with many other hospitals (particularly teaching hospitals) and is competing with them for the same patients.

  Since community hospitals draw the majority of their patients from the towns that surround them, community coalitions and their member organizations have a critical role to play in helping the hospital market itself to patients.

  - **Who are the patients? Who aren't the patients?** In Waltham, the bulk of the patients were long-time residents who had been using Waltham Hospital for most of their lives. But Waltham also has a growing population of young professionals who were more likely to see care at one of the prestigious teaching hospitals in Boston. Waltham Hospital needed to attract more of these residents to seek care in their hometown.

  - **Vicious cycle of departures:** Even after the closure was averted and the hospital remained open in 2002, the hospital found itself losing patients and staff. Fears remained about the possibility of the hospital closing in the future. Patients worried about whether the hospital would really be there when they needed it, and so began seeking care elsewhere. Hospital staff began worrying about whether their jobs at the hospital were secure, and so began looking for jobs in anticipation of a future closure. The result was a self-fulfilling prophecy – with fewer patients, the hospital continued to lose money. With fewer staff, morale went down and more staff left, further undermining patients' confidence in the hospital. The cycle spiraled downward from there, eventually resulting in the hospital's closure.

  - **Once out of the frying pan, don't get burned (out!):** The Coalition to Save Waltham Hospital and the residents of Waltham waged an aggressive and creative campaign, but one that left them burned out – by the time the hospital had been transferred to its new owner and new Board, people were exhausted. They were relieved that the hospital was not closing, and the work of the Coalition more or less ceased. The moral of the story is that fighting to save hospital services is a marathon, not a sprint. There will be times of frenetic activity, but make sure you reserve some strength and energy for the long haul.

  - **Think globally, act regionally:** Waltham Hospital was the first hospital to completely shut its doors under Massachusetts' Essential Services Law. Many

fear that it is not the last. We hope that it will have served as the "canary in the coal mine," alerting decision makers to the crisis facing small and community hospitals around our state. The campaign and the closure underscored that a hospital does not exist in isolation from the community and region in which it is located. What is ultimately needed to help hospitals survive and prosper is **regional health planning** that looks at the health care needs of the entire area in a comprehensive way, that brings together state agencies, local governments, legislators, health insurers, health providers, hospital administrators and residents, and that does not expose the life-saving function of hospitals to the undiluted force of the "free market."

# *Appendix A: Waltham Hospital Chronology and Dossier*


***Stage 1*: The Hospital is kept open**

**January 11, 2002:** CareGroup, Inc., parent organization of Deaconess-Waltham Hospital puts Department of Public Health (DPH) on notice that it will close the hospital on April 11, 2002.

> **Exhibit A: January 2002:** Coalition to Save Deaconess-Waltham Hospital develops work plan for big turnout at DPH public hearing, set for February 11, 2002.

**February 1, 2002:** On behalf of Coalition, HLA puts DPH on notice that it will be representing the Coalition at the public hearing. HLA also requests 10 minutes to present public testimony at hearing and copies of all correspondence between DPH and CareGroup regarding "essential services."

> **Exhibit B: Early February, 2002:** Coalition Flyer posted around Waltham to get turnout for DPH hearing.
>
> **Exhibit C**: **February 11, 2002:** Sample "form letter" signed by over 300 Waltham seniors and submitted to the DPH at the public hearing.

**February 11, 2002: Health Law Advocates submits testimony** on behalf of the Coalition. *(Available at http://www.hla-inc.org/public/testimony.public.hearing.doc)*

> **Exhibit D**: **February 11, 2002**: **Testimony submitted by three Waltham community leaders:** from the Council on Aging, Immanuel United Methodist Church, and the Waltham Building Department. *(Available at http://www.hla-inc.org/public/ CoalitionTestimony.doc)*
>
> **Exhibit E: February 18, 2002**: **DPH Finding of Necessity.** DPH finds the *entire* hospital, both in-patient and out-patient services, to be "essential." DPH requests CareGroup to submit a Plan for assuring continued access to all services offered at Deaconess-Waltham Hospital. *CareGroup's closure plan not enclosed.*

**February/March, 2002:** Developer begins negotiation with CareGroup and Coalition to Save Deaconess-Waltham Hospital to develop plan to save hospital from closure.

**March 7, 2002: Boston Globe editorial** calls for keeping hospital open. Substantial daily press also generated by local paper, **The Daily News Tribune** in Waltham.

**March 14, 2002: HLA and Coalition submit** 300 letters from Waltham senior citizens to DPH, regarding inadequacy of CareGroup's closure plan on continued access to services.

**March 15, 2002:** HLA submits comments on CareGroup's Plan, on behalf of Coalition, calling for DPH rejection of plan. *(Available at http://www.hla-inc.org/public/CareGroupplancomments402.doc)*

> **Exhibit F: March 27, 2002, article in The Daily News Tribune.** CareGroup, Developer and Coalition sign agreement to keep hospital open until final recovery plan can be developed.

**April 23, 2002:** DPH writes to CareGroup, confirming CareGroup's agreement with the Coalition and developer to transfer control of the Hospital to the new Waltham Hospital board of trustees and keep hospital open.

**Stage 2: The Hospital is forced to close.**

**May 13, 2003:** Board of Trustees of Waltham Hospital votes to close the facility by end of July 2003.

**May 15, 2003:** Hospital notifies DPH of its intent to discontinue services on or about July 29, 2003.

**May 16, 2003:** DPH approves Hospital's request to waive the requirement of providing at least 90 days notice before closing the hospital, clearing the way for closure by July 29, 2003.

> **Exhibit G: May 29, 2003, HLA submits testimony at DPH hearing**, attended by 80-100 Waltham residents, in contrast to the over 1000 attendees at the February 11, 2002 hearing.

**June 3, 2003:** Newton-Wellesley Hospital and Caritas St. Elizabeth's Medical Center, the two nearest hospitals to Waltham, begin operating daily shuttle buses from the site of Waltham Hospital.

**June 9, 2003: DPH Finding of Necessity.** As in 2002, DPH finds the entire hospital, both in-patient and out-patient services, to be "essential," and requests the hospital to submit a plan for continued access to those services.

**June 23, 2003:** Hospital submits closure plan to the DPH.

**June 25, 2003:** DPH "provisionally" approves the hospital's closure plan, requests additional information on the ambulance travel times, public transportation issues and the proposed urgent care center before granting final approval.

**July 29, 2003:** Waltham Hospital closes its doors for good.

## Exhibit A

# Proposed Work Plan - Coalition to Save Waltham Hospital

**Re: Dept. of Public Health public hearing; Feb. 11, 2002, Waltham High School**

**OUR MESSAGE:** We are here to tell the Dept. of Public Health we oppose the closure of Deaconess Waltham Hospital. Closure will cause the elimination of essential hospital services such as the emergency department, the 23 psychiatric beds, and the dialysis unit. The closure will jeopardize the health and well being of vulnerable residents of Waltham and our surrounding communities. This hospital cannot close until these critical access problems are solved.

**Other tips:**

- Don't demonize Care Group or anyone else
- Don't say Beth Israel can never close
- Remember, the Coalition is about gaining friends and problem solving *together*

**Team captains: Your job is to organize testimony for your issue to bring back to the planning group.** Please contact your people, talk to them about the public hearing and see if they are interested in participating and what they have to say about the issue. If you deem they have valuable testimony, ask if they would be willing to present 3 minutes of testimony on 2/11 and get a sense of that their testimony would include. It is best if they would be willing to submit written and oral testimony, but we understand written testimony may be difficult for some people so just oral testimony is better than nothing.

**I. <u>Emergency Services</u>**: (Team captains: Dr. Richard Lyons, Laurie Martinelli)

A. <u>General testimony</u> about diversions in Region 4, the stress this causes on area hospitals, and the danger to patients:

1. MA Hospital Association and Jeff Cole, CEO of Emerson Hospital (Senator Fargo)
2. Dr. Alan Woodward, Dir. of ER at Emerson Hospital (Senator Fargo)
3. Steve Nelson, Director, EMS Region 4 (Laurie Martinelli)
4. Dr. Richard Lyons, patient census at Deaconess Waltham ED, where will these patients go?

B. <u>Public Safety component</u>: We will recruit Fire and Police Department Chiefs from Waltham and neighboring towns to talk about problems relating to delays, longer transports, affect on families, etc. (Patrice McDonald)

1. Waltham Fire and Police Chief (Patrice McDonald)
2. Same for neighboring towns (Patrice McDonald)

3. Brandeis security staff (Michal Regenberg)
4. Steve Cohen, State Fire Marshall, homeland security and role of Deaconess Waltham Hospital (Senator Fargo)

**II. Psychiatric Beds:** (Team captain: Kelly Cooper) NOTE: We need more background information here. What services are currently offered? What beds are considered "essential." How many beds dedicated to each? Are there plans to transfer the eating disorder unit elsewhere?

1. National Alliance for Mentally Ill (NAMI), Toby Fisher, including parents and patients (Kelly Cooper)
2. Dr. Ramona Dvorak, Mt. Auburn Hospital
3. Other referral staff from area mental health units would be very helpful (Kelly?)
4. Commissioner Mary Lou Sudders, Dept. of Mental Health (Laurie Martinelli)
5. Dr. Dennis **Jackonowski??? (Who, is this Kelly?)**
6. Patient census from area hospitals (Newton-Wellesley, Mt. Auburn, St. Elizabeth's, McLean Hospital, more?) (Laurie Martinelli)

**III. Dialysis Unit** (Team captains Dianne Koch, Patti Camuti) NOTE: We need additional information here as well. What is the current capacity of this unit? What has been the average patient census for the past year at least? What vulnerable patients does it serve? Is there a waiting list? Is there other capacity nearby that can serve these patients? We really need to investigate this carefully before we declare it an "essential" service at the public hearing.

1. Dr. Mawya Shocair, nephrologist, runs the unit, (she needs to talk about her patients, their vulnerable status? Where they'll go for these services if it closes) (Dianne Koch)
2. Waltham Dialysis Unit (Maureen Chartier)
3. Outpatient Dialysis unit in Wellesley (Maureen Chartier)
4. Any other dialysis services that are nearby (Dianne and Patty)

THEN IF WE DECIDE IT IS "ESSENTIAL,"

5. Patients, their family and friends

**IV. Vulnerable people:** (Team captain, Maria Aviles)

1. Maria **Aviles**, affiliation? (Diane Koch)
2. Fr. Wendell Verrill, St Mary's Church (Maria Aviles)
3. Frederico Rivera (who?)
4. Free Clinic, Nancy Hargraves (who will contact)
5. Pete Donovan, Middlesex Human Services Agency, (Tony Mangini)
6. Greater Boston Interfaith Coalition (GBIO), (Peter Lin Marcus)
7. Waltham Council on Aging (Rep. Tom Stanley)
8. Carol Tagg, Waltham Association for Retarded Citizens (Dianne Koch)
9. Reverend Ezequiel Gonzalez, Pastor, Emmanuel United Methodist Church, (?)
10. Mass. Senior Action Council (Bob Marra)
11. Other community coalition representatives other than Sally Tracy (Bob Marra, HCFA)
12. More?

## Exhibit B: Coalition Flyer

# Department of Public Health Hearing

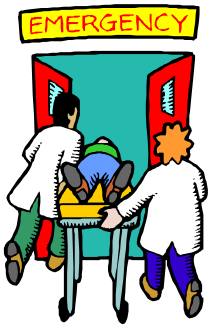
The Department of Public Health is coming to Waltham to hear from YOU about the Plans to Close Deaconess Waltham Hospital. Come TESTIFY about how closing the hospital will affect your family and community. SPEAK OUT about the need to keep these essential hospital services.

- **Monday, February 11th, 6:00 PM**
- **Waltham High School, Robinson Auditorium, 617 Lexington Street, Waltham**

### Tell the Department of Public Health

# Save Deaconess Waltham Hospital!

Deaconess Waltham Hospital provides essential medical services to Waltham and its neighbors – services like the **Emergency Room**, **Psychiatric Care** and **Dialysis**. Losing these services would jeopardize the health and safety of all of us, particularly our community's most vulnerable - the elderly, chronically ill, and uninsured.




**Come to the Hearing on 2/11 – Testify – Show Your Support for Keeping Deaconess Waltham Hospital Open!**

*For more info, or to get involved, call the Coalition to Save Waltham Hospital: 781-*

# Exhibit C: Sample Form Letter

Commissioner Howard Koh
Department of Public Health Law Advocates
250 Washington Street
Boston, MA 02108

Dear Commissioner Koh:

I am writing to express my profound concern over the proposed closure of Deaconess Waltham Hospital and the loss of its essential services. As a resident of Waltham, I know that this closure will seriously impact the health and safety of all residents in Waltham, and the surrounding communities, particularly the chronically ill, elderly and disabled. As you know, our region has the highest emergency room diversion rates in the state. Lahey Clinic, Newton-Wellesley Hospital, Mt. Auburn and other area hospitals already have significant delays and frequent diversion in their Emergency Rooms. Adding to this the more than 20,000 people a year who use Deaconess Waltham's Emergency Room will make a difficult situation even worse. In an emergency, the added delay might quite literally mean the difference between life and death.

As a senior citizen, I worry about what would happen to me in the event of an emergency. Will the extra time it takes to get me to another emergency room, plus a longer wait, be the difference between life and death for me?

I urge you to do everything in your power as the Commissioner of the Department of Public Health to keep Deaconess Waltham Hospital open and preserve its essential services.

Sincerely,

_____ _____
Signature Date

Print Name:

Address, City, State, Zip:

In addition, I have other concerns about the closure of the hospital, or want to relate how the hospital has been essential to the health of my family and me:

_____

_____

_____

# Exhibit D: Waltham Community Leaders' Testimony

**Testimony of the Coalition to Save Deaconess Waltham Hospital**
**Before the Department of Public Health Hearing on Essential Services**
**February 11, 2002**

## Introduction

Commissioner Koh, my name is Ruth Gately. I am one of the representatives of the Coalition to Save Deaconess Waltham Hospital. The Coalition formed on January 10, 2002, as soon as we learned of CareGroup's plans to close the hospital. Our mission is to wake up our community and mobilize them to fight to save our hospital. Our goal here today is to call attention to the negative effects on our health of losing the hospital's essential services and urge you to keep our hospital open. The Coalition includes doctors, nurses, hospital staff, patients, community leaders, clergy, human service providers, seniors and many other Waltham residents and people concerned about the fate of our hospital. Many of the Coalition's members have come tonight to express to you the importance of keeping our hospital open.

I am going to testify first, followed by Reverend Ezequiel Gonzalez of the Immanuel United Methodist Church, and then by Jerry LeBlanc, Access Analyst for the City of Waltham.

## Ruth Gately

I am the Director of the Waltham Council on Aging. The Council provides services, activities and programs to seniors in Waltham. Most importantly, I serve as an advocate for this very special group. I speak on behalf of the 10,000 seniors in Waltham who comprise one-sixth of our city's population. The health and well-being of Waltham's seniors will be gravely threatened if Deaconess Waltham Hospital closes. Seniors utilize the services at the hospital far more than other people—we know this in part because Medicare is the Hospital's single largest payor.

Seniors in Waltham now know that we are in a crisis. They are concerned about their health and their access to health care. They already face daily worries over their health insurance, paying for prescriptions, affordable housing, making ends meet on a fixed income, battling grief over the loss of their loved ones, and their own declining health. They are of course concerned about the loss of routine and specialty care at Deaconess Waltham Hospital, but of particular concern is the loss of the emergency room. Seniors are the chief users of the Emergency Room, because they more frequently face immediate and life-threatening medical situations. We know that diversion is a huge problem for hospitals in the area – very often ambulances can't take people in emergency situations to the closest emergency room because it is on diversion. Closing our hospital will not only make the diversion problem worse. It will also add to the time it takes to get a senior in an immediate life-threatening crisis to life-saving care in the E.R. It will also add to already-long delays in those other emergency rooms. What's going to happen when all the people who use Deaconess Waltham Hospital's E.R. suddenly get added to all those people waiting in the E.R.s of Lahey Clinic, Mt. Auburn Hospital, and Newton-Wellesley Hospital? I recently learned of a Waltham man, in his 70s,

who was rushed to the emergency room at the Lahey Clinic. He was forced to wait eighteen hours in the E.R. before he was cared for. How much longer will seniors like him wait if Deaconess Waltham Hospital closes? How many people will needlessly die as a result?

The seniors of Waltham are the ones who made this city into the vibrant and welcoming community it is today. They deserve to receive high-quality medical care in their own community. Closing the hospital means gambling with their lives. Commissioner Koh, on behalf of the seniors of Waltham, I urge to do everything you can to keep our hospital open and protect the health of our most vulnerable, the seniors.

**Reverend Ezequiel E. Gonzalez**

Thank you for the opportunity to testify to day. I am Reverend Ezequiel E. Gonzalez, and I am the pastor of Immanuel United Methodist Church. My church is on the South Side of Waltham, in the same neighborhood as Deaconess Waltham Hospital. I am here to speak on behalf of my church and its members, and on behalf of the free health clinic housed in our church. Over the past three years, our free health clinic has served over 2,000 people, providing them with much needed screenings, tests, prescriptions and other services. The clinic is staffed by volunteer doctors and nurses from Deaconess Waltham Hospital.

It is no exaggeration to say that if Deaconess Waltham Hospital closes, our free health clinic will have to close. Not only does the hospital provide the doctors and nurses who volunteer their time at the clinic, but it also performs lab work, X-rays and other tests for the patients seen at our clinic. In addition, many patients receive follow-up care at the Hospital itself. In many ways, our church's free clinic has served as a conduit to the Hospital, enabling and encouraging poor and immigrant families who might not otherwise have gone for care at the Hospital to get care that is absolute vital to their health and well-being. Many of the people seen at our clinic are low-income and many are immigrants. It is these populations that will be hurt the most if the hospital closes.

If Deaconess Waltham Hospital closes, our clinic will have to close because we depend on our relationship with the hospital in order to provide necessary services to our patients. Such a relationship would simply not be possible with a hospital located farther away. It is the proximity of Deaconess Waltham Hospital that matters, as well as the dedication and commitment of its staff to our clinic.

Beyond our free clinic, however, I am concerned on an even deeper level about the effect that closing the hospital would have on our community, particularly those who are most vulnerable. There are already numerous obstacles that hinder the ability of vulnerable people in Waltham to get medical care—lack of transportation, lack of insurance, unfamiliarity with the health care system, etc. The loss of a high-quality community hospital in our City will greatly increase the likelihood that many of these vulnerable people will not receive the medical care they so desperately need. The absence of an Emergency Room in Waltham puts us all at great risk. The added transportation time and delay in going to a more distant and more crowded Emergency Room will no doubt mean the difference between life and death for some patients. What do we tell those families whose loved ones didn't survive because there wasn't an emergency room close by in a moment of crisis?

As a pastor, the words of the Bible are never far from my heart. As a Christian, I believe in the resurrection of the impossible. Although it seems that the hospital's days are numbered, I still see the possibility to keep it open. The hospital is on Hope Avenue, and we need to keep the hope alive. Deaconess Waltham Hospital sits atop a hill. In Psalm 121, it says "I will lift up my eyes to the hills. Where does my help come from?" Commissioner Koh, if Deaconess Waltham Hospital closes, the residents of Waltham will all too soon be asking themselves that same question. I ask you to do everything in your power to ensure that Deaconess Waltham Hospital stays open, and remains that beacon of healing on the hill. Thank you.

**Jerry LeBlanc**

My name is Jerry LeBlanc. I work as an Access Analyst with the City of Waltham Building Department to make sure all buildings are handicapped accessible. I am concerned about the effect that closing Deaconess Waltham Hospital would have on disabled people in Waltham. Nationally, approximately 20% of the population has some type of disability.[*] In Waltham, this means that it is likely that more than 10,000 residents have disabilities of one kind or another. The disabled generally have greater medical needs than the non-disabled. Closing the hospital will impact them very negatively.

I am concerned particularly about the loss of our emergency room. When I have personally gone to the Emergency Room at Lahey Clinic, I have had to wait anywhere from 3 to 10 hours to receive care. If we lose our ER right here in Waltham, that wait at the other hospitals in the area will be much greater. We all know that such delays can mean worsening of the condition that we went to the ER to get treated. For many people, that wait will have a permanent impact.

Many disabled people lack transportation – many don't drive, and there is no public transportation to many places in our area. In an emergency, one can always call an ambulance—but what about routine appointments, and urgent care? Disabled people already face enough obstacles to getting the care they need. Having to find transportation to a more distant hospital will no doubt prevent or discourage some people from getting care at all. Even a few miles can be the difference between getting care and not getting care. Having a hospital right here in Waltham is necessary for the health and well-being of Waltham's disabled residents.

On behalf of Waltham's disabled community, I ask you to keep our hospital open. Thank you.

[*]U.S. Census Bureau, *Americans with Disabilities 1997*

# Exhibit E: DPH Finding of Necessity



JANE SWIFT
GOVERNOR
ROBERT P. GITTENS
SECRETARY
HOWARD K. KOH, M.D., MPH
COMMISSIONER

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor, Boston, MA 02111
(617) 753-8000

February 18, 2002

Joseph D. Dionisio
Chief Financial Officer
CareGroup HealthCare System
375 Longwood Avenue
Boston, MA 02215

RE: Closure of the Deaconess Waltham Hospital,
Hope Avenue, Waltham, MA 02453

Dear Mr.Dionisio:

On January 11,2002 the Department of Public Health received a notice from CareGroup, HealthCare System, the sole corporate member of Deaconess-Waltham Hospital regarding their intent to discontinue providing all In-Patient and Ambulatory Care Services at Deaconess Waltham Hospital located at Hope Avenue, Waltham, MA 02453 (the Hospital), resulting in closure on or about April 11, 2002.

Pursuant to 105 CMR 130.122(E), the Department scheduled a public hearing to receive oral and written comments on that proposal. A hearing was held on February 11, 2002; approximately 1300 people attended, and 100 people gave oral and written testimony.

The Department has considered all of the comments received at the hearing and has examined the current utilization of the services, reviewed the capacity of alternative service sites to provide the services, travel times to alternative service delivery sites, and the clinical importance of local access to the service, and finds, pursuant to 105 CMR 130.122(F), that the services that CareGroup, contemplates discontinuing at the Hospital, are necessary for preserving access and health status in the hospital's service area.

Consequently, the hospital must submit a plan for assuring access to Inpatient and Ambulatory Care Services following their discontinuance at Hope Avenue, Waltham, MA 02453. The plan must at a minimum, include for each inpatient and ambulatory care service the following elements:

1. A protocol that describes how patients in the hospital's service area will access the services at alternative delivery sites. Please address how access will be assured for all providers, agencies and payers who currently constitute a referral source for patients admitted to Deaconess Waltham Hospital.

2. Updated information on utilization of services prior to the proposed closure.
   a) Admissions and/or discharges
   b) Occupancy rates
   c) Length of stay
   d) Patient origin
   e) Payer mix

3. Information on the location and service capacity of alternative delivery sites. Include an explanation of the basis for the Hospital's determination that the alternative delivery sites have the capacity (necessary space, resources, etc.) to handle the increased patient volume at the identified sites. To support that assertion, please provide the following specific details:
   a) Number and type of providers
   b) Current utilization at these alternative sites
   c) Type of services available at the alternative sites
   d) Adequacy of space and resources at the alternative sites.

4. Travel times to alternate service delivery sites.

5. An assessment of transportation needs and the clinical implications for all inpatients and outpatients post discontinuance, and a plan for meeting those needs. Describe the transportation that is and will be available for patients to access inpatient and ambulatory care services at alternative delivery sites.

6. A protocol that details mechanisms to maintain continuity of care for current patients of the discontinued service. Include plans for carrying out an individualized relocation and discharge plans for current patients – describe when, how and by whom patients will be informed about the closure, and how patients will be informed of available alternative sites or providers.

7. In addition, please provide the names of and types of the other providers who occupy the Deaconess-Waltham Hospital and describe how they will be affected by CareGroup's proposal to discontinue services at the site.

The hospital's plan for assuring access to discontinued services must be submitted to the Department, 10 West Street, Boston, MA 02111 no later than 5 PM on March 5, 2002. If you have any questions, please contact Carolina Casares at (617) 753-8134.

Sincerely,

Paul I. Dreyer, Ph.D
Director
Division of Health Care Quality

Cc: Dianne McCarthy, Esq. Assistant General Council, CareGroup
Robert P. Gittens, Secretary, EOHHS
Howard K.Koh, Commissioner,DPH
Marylou Sudders, Commissioner, DMH
Wendy Warring, Commissioner, DMA
Louis Freedman, Commissioner, DHCF&P
Nancy Ridley, Assistant Commissioner, DPH
Greg Casey, Legislative Liaison, DPH
Laurie A. Martinelli, HLA's Coalition to Save Deaconess-Waltham
Dr. Richard G. Lyons, Coalition to Save Deaconess-Waltham
Steven A. Tolman, State Senator
Susan C. Fargo, State Senator
Peter J. Koutoujian, State Representative
Thomas M. Stanley, State Representative
Rosario Malone, Waltham City Council Clerk
David F. Gately, Mayor City of Waltham
Jean Pontikas, DHCQ
Carolina Casares, DHCQ
Kathleen Coyle, DHCQ
Gail Palmeri, DHCQ
Carl Rosenfield, DPH, OGC

# Exhibit F: Daily News Tribune article

The DAILY NEWS TRIBUNE

http://www.dailynewstribune.com/news/local_regional/walt_hospital03272002.htm

## Hospital deal signed: CareGroup to remain in control of facility until a recovery plan is formed

*By Patrick Golden*
Wednesday, March 27, 2002

WALTHAM - A formal agreement was signed last night to begin a recovery plan at Deaconess-Waltham Hospital and transfer the facility's ownership to a new local group by the end of May.

The highly anticipated agreement between CareGroup, developer Roy MacDowell and the Coalition to Save Waltham Hospital was consummated nearly two weeks after the parties reached an understanding on major points of the transfer deal.

CareGroup and Deaconess-Waltham Hospital board members signed the agreement late yesterday afternoon before it was whisked off to be signed by MacDowell and the coalition.

"We are pleased that we have reached agreement on this issue and extend our full support to the coalition as they continue their transition planning over the next several weeks," said Harold Hestnes, the Deaconess-Waltham Hospital board chairman.

The agreement gives MacDowell and the coalition unfettered movement in directing a recovery plan. CareGroup will own the hospital until the transfer, but the signed agreement gives MacDowell and the coalition more clout to make decisions.

"The signing of this agreement allows us to move forward and finalize the various elements of our plan," said MacDowell.

Hospital consultants Cambio Health Solutions began work last week on a recovery plan. Tufts New England Medical Center is also assisting in the recovery effort.

The deal still needs the approval of the state Attorney General's office and Department of Public Health.

MacDowell has agreed to pay $2.5 million to cover the hospital's operating losses while the recovery plan is assembled, and will pay $5.5 million to purchase the hospital's real estate. The hospital facility and its equipment will be controlled by a new, local non-profit group.

With an official agreement to proceed signed, much of the attention regarding the hospital's turnaround will shift to the City Council, which will likely be asked to rezone the hospital property to make way for a 300-unit apartment complex on land currently used for parking. No plans have been submitted with the council.

The City Council is seeking guidance on how it should handle its future involvement in the bid to save Deaconess-Waltham Hospital. The council has asked Mayor David Gately to consider hiring a consultant to conduct an independent study of the hospital's impending business recovery plan.

"Shame on us if, when the 11th hour is here, we have not done all we can to be ready," said Ward 8 Councilor Stephen Rourke at Monday's council meeting.

Councilor at large Jeannette McCarthy filed a resolution asking for the Law Department to issue an opinion on what the council can say about the hospital effort in the coming weeks. Councilors are prohibited from taking public stances on zoning change requests prior to a public hearing.

Some councilors have said they want to see a hospital recovery plan before they agree to zoning changes or financial assistance.

The council in February asked the state Legislature for permission to loan up to $2 million to the hospital. The matter is before the Joint Committee on Health Care.

"There are many concerned citizens and friends of the community who are working around the clock to give Waltham Hospital a new lease on life," said Rourke.

http://www.dailynewstribune.com/news/local_regional/walt_hospital03272002.htm

# Exhibit G: HLA's comments to DPH on Hospital's closure

HLA
Health Law Advocates, Inc.
Health Care For All's Public Interest Law Firm



Health Law Advocates, Inc.
30 Winter Street Suite 940
Boston, MA 02108
Tel: 617- 338 - 5241
Fax: 617- 338 - 5242
www.hla-inc.org

June 6, 2003

Commissioner Ferguson
C/o Carolina Cesares
Department of Public Health
Division of Health Care Quality
10 West Street, 5th Floor
Boston, MA 02111

Via Fax: 617-753-8095

Re: Comments on Closure of Waltham Hospital

Dear Commissioner Ferguson:

Please accept these written comments as a supplement to our oral testimony at last week's public hearing at Waltham High School concerning the pending closure of Waltham Hospital.

Health Law Advocates, Inc. is a public interest law firm affiliated with Health Care For All. In February 2002, HLA represented the Coalition to Save Deaconess Waltham Hospital (hereafter "Coalition") in the previous "essential service" public hearing required by Massachusetts General Law, Ch. 111, section 51G.

Now as then, we remain gravely concerned about the effect that the closure of Waltham Hospital will have on the residents of Waltham and the surrounding communities, as well as the effect on the regional health care system as a whole.

We urge the Department of Public Health to take an active and aggressive role in leading a comprehensive planning process to address the health care needs of Waltham and the surrounding communities. The closure of Waltham hospital will be a test case that hospitals, communities and advocates around the state will be closely watching. What happened in Waltham is likely to happen elsewhere. What happens in the aftermath of the closure will determine how future closures are addressed and whether we as a state merely bemoan the loss of one hospital after another or whether we take such closures as a grave warning sign that our hospital system in Massachusetts is in jeopardy.

The Department of Public Health is the agency charged by the

Legislature with addressing this issue. It is also the agency best situated to bring together the different communities and stakeholders who can address this crisis. With this as the overriding context, Health Law Advocates and Health Care For All submit the more specific comments below:

**1. The services of the hospital remain essential**

On February 18, 2002, the Department determined, pursuant to 105 CMR 130.122(F), that all of the services at Waltham Hospital "are necessary for preserving access and health status in the hospital's service area." In the intervening year, the management of the Hospital was transferred from CareGroup to an independent Board of Trustees. However, the necessity of the services provided at the hospital did not change. They are just as essential today as they were a year ago, if not moreso.

M.G.L. c. 111 §51G requires the department to make an individualized determination of necessity whenever a hospital announces its intent to close. §51G thus requires a new determination of necessity for Waltham Hospital, despite the fact that the Department made such a determination last February. We urge the DPH to reiterate its previous determination that all of the services at Waltham Hospital are essential.

The Department's regulations at 105 CMR 122 require a specific series of steps that the Department must take when a hospital plans to close. However, M.G.L. c. 111 § 51G gives the Department a much broader mandate than is covered by these regulations. That section says that

> *The department shall, in the event that a hospital proposes to discontinue an essential health service or services, determine whether any such discontinued services are necessary for preserving access and health status in the hospital's service area, require hospitals to submit a plan for assuring access to such necessary services following the hospital's closure of the service,* ***and assure continuing access to such services*** *in the event that the department determines that their closure will significantly reduce access to necessary services. [emphasis supplied]*

Thus, the Legislature has charged the Department with taking whatever steps it has the power to take in order to assure continuing access to necessary services. This suggests a broader role for the Department in the closure of Waltham Hospital than merely shepherding the hearing process in 105 CMR 122.

**We call upon the Department, as the state agency responsible for ensuring the public's access to adequate health care, to take the lead in helping the Hospital and the City of Waltham plan how its essential health care needs are going to be met.**

To accomplish this goal, the Department should bring together all the parties and institutions concerned with health care access in Waltham and the region, including:

- The board and staff of the hospital
- The Mayor of Waltham and the City Council
- The Fire, Police and Emergency Services departments of Waltham

- Community organizations, religious congregations and social service providers in and around Waltham
- The Legislative delegation representing Waltham
- The patients of the hospital, particularly seniors and the uninsured
- Roy MacDowell, the developer who purchased the parcel on which the Hospital sits
- The surrounding towns whose residents also currently use the hospital
- The other hospitals and the health centers in the area who will see increased demand and patient volume after the hospital closes

**2. Specific issues raised by the hospital closure**

While all of the services at the hospital remain essential, there are several of special importance:

# Emergency Services

Many groups in Waltham are concerned about the effects of not having an emergency room right in Waltham. The police, fire and emergency medical departments of the city worry about the effect this will have on not just the patients who need emergency care, but on the fire and police services themselves, as increased travel times to more distant hospitals will place an additional burden on the city's first responders and emergency personnel.

Diversion rates for all the hospitals in the area have consistently been going up over the past three years, as the attached charts demonstrate (see Appendix A). Waltham Hospital had 17,000 emergency room visits last year. These 17,000 people will go somewhere else after the hospital closes. This will increase the strain on the other area hospitals and increase the frequency they are on diversion. It is likely that many of the 17,000 visits were not true emergencies, and could be appropriately treated in less-intensive settings.

The Department must ensure that this additional strain does not put patients at risk. We urge the Department to require the following steps as part of the closure plan for the hospital, not just prior to the date of the hospital's closure but extending beyond that date:

- Convene a meeting or series of meetings to determine how to ensure that adequate resources exist in and near Waltham for both emergencies and those medical needs that are not true emergencies (such as an urgent care center, community health center, or some combination of these two), with representatives from:
    - the towns of Waltham and the towns whose residents comprise the top 5 sources of non-Waltham patients at Waltham Hospital,
    - the 5 hospitals closest to Waltham and from the towns whose residents comprise the top 5 sources of patients at each of those hospitals,
    - the fire, police, and emergency services departments of Waltham and its immediate surrounding towns,
    - social, medical (non-hospital) and human services providers serving Waltham residents (including those providers located near but not in Waltham),

particularly those serving vulnerable populations such as seniors, low-income people, the uninsured, the disabled and immigrants.

- Educate residents about where to get urgent but non-emergency care, such as through the publication of a multilingual guide to medical services available in the area and the appropriate uses of primary care, urgent care, and emergency room settings.

## Mental health beds

Neither Waltham nor Massachusetts can afford to lose any mental health beds. The Department and the Hospital must make sure that there is **no net loss** of the 42 mental health beds currently at Waltham Hospital. The Department of Mental Health beds, the eating disorders unit and the substance abuse beds are all vitally important to the entire region.

## Basic outpatient care

The residents of Waltham will continue to need basic outpatient care. While many of them will seek it at other hospitals, planning is essential to ensure that everyone in Waltham is able to get care when they need it.

Although other hospitals in the area, such as Newton-Wellesley and St. Elizabeth's, have stated that they have the capacity to absorb the additional demand created by the closure of Waltham Hospital, we urge the Department to thoroughly scrutinize these assertions and the data they are based on.

It is not enough to merely look at the capacity of other institutions and conclude that care can be had elsewhere. Planning is necessary to ensure that care is actually available, particularly for seniors, low-income people and the uninsured.

Newton-Wellesley Hospital recently announced that it will offer 24-hour urgent care services in Waltham Hospital's emergency room once the hospital closes. In addition, the Joseph Smith Community Health Center has expressed its willingness to open a health center in Waltham. We are very pleased that these two institutions have stepped up to the plate to provide much-needed services in Waltham. We encourage the Department to do whatever it can to assist these efforts, such as expediting and facilitating any needed transfer or granting of licenses and assisting the parties in seeking City and State assistance needed to make these plans possible (such as the need for affordable or subsidized space for a health center).

While we applaud the efforts of these two organizations and the Board of the Hospital to locate an urgent care center and community health center in Waltham, we feel that by themselves these institutions would not adequately assure continuing access to the essential services currently provided by Waltham Hospital. We urge the Department to lead a community and regional planning process to address the issues of transportation, community benefits and free care, and linguistic access.

# Conclusion

We urge the Department to use the regulatory process in the essential services regulations (105 CMR 122) as a springboard for a more comprehensive regional planning process. Specifically, we encourage the Department to:

- Use its review of the Hospital's plan as required by 105 CMR 122(G) to solicit input from the parties described in this testimony.
- Thoroughly scrutinize that plan and do its own investigation to verify the capacity of other institutions in the area to meet the increased need created by the Hospital's closure.
- Closely monitor the availability of the services deemed essential after the hospital closes, and use the post-closure report required in 105 CMR 122(I) to solicit further input about that availability from all the parties listed in this testimony. If the Department determines in that report that any essential service has become unavailable or inadequate, the Department should convene a hearing of all interested and affected parties to determine what additional steps the Department and others can take to ensure availability of those services.

The closure of Waltham Hospital will be the first full closure of a hospital under the Essential Services law, and the first closure under the tenure of Commissioner Ferguson. This will set the tone for any future closures. Using Waltham and the surrounding community as an opportunity to do real planning on how to meet this community's health needs will set an invaluable precedent for when this occurs elsewhere. The Department must be the driving force for this process and its oversight must continue beyond the date the hospital closes.

Our region's hospitals are like the support beams of a house – losing one of them places a strain on all the others. There is no doubt that the closure of Waltham Hospital will place an increased strain on the other hospitals in the area. Many of our hospitals are facing significant financial obstacles. Waltham is the canary in the coalmine of our hospital system in Massachusetts. The Department must work to prevent the closure of Waltham Hospital from having a cascade or domino effect on the other hospitals in the area.

The tragedy of the closure of Waltham Hospital presents the Department with a unique leadership opportunity at a critical moment in the Massachusetts health care system. We hope the Department will seize that opportunity to call attention to the grave problems faced by our health care system and engage all of the concerned parties in a far-reaching effort to ensure that this does not happen again. We look forward to working with you to make this a reality.

Cc: Mayor David Gately, City of Waltham
Representative Peter Koutoujian
Representative Thomas Stanley
Senator Susan Fargo
Tony Mangini, Waltham Hospital
Diane Koch
Alan Woodward, Mass. Medical Society
Kathleen Phoenix, Joseph Smith Community Health Center
Clerk of the Waltham City Council

# *APPENDIX B: RESOURCE LIST*

**Health Law Advocates** (HLA) is a nonprofit, public interest law firm founded in 1996. HLA provides free legal representation to eligible consumers that live or work in Massachusetts and are seeking access to adequate health care services. HLA also fights for health care justice through the representation of groups of consumers and communities and through education and outreach.

HLA is affiliated with Health Care For All, a premier consumer advocacy organization whose mission is to build a movement of empowered people and communities, with the goal of creating a health care system that is responsive to the needs of all people.

HLA is the only non-profit law firm in the country affiliated with a grass roots organization and dedicated solely to ensuring access to health care for society's most vulnerable members, including the chronically ill and uninsured.

**Community Catalyst** (www.communitycatalyst.org) is a nonprofit, national health care advocacy organization dedicated to building consumer and community participation in the decisions that shape the health system to ensure quality, affordable health care for all. Community Catalyst is working with consumer advocates around the country to expand health care access, improve health care quality, preserve health care resources amid hospital and health plan restructuring, strengthen the capacity of consumer health advocacy groups, and build state and regional networks to support advocacy for needed policy and system change.

In addition to the work it does on health industry restructuring through its Community Health Assets Project collaboration with Consumers Union, Community Catalyst's other projects include the Prescription Access Litigation (PAL) project on prescription drug prices; the RealBenefits project, which facilitates access to public health and human service services for low-income families and individuals; and its Community Benefit and Free Care Initiative, focused on persuading hospitals to be more responsive to the real health needs of their communities.

## LINKS TO MASSACHUSETTS' ESSENTIAL SERVICES LAW AND REGULATIONS

**Mass. Gen. Laws Ch. 111 § 51G:**
*www.state.ma.us/legis/laws/mgl/111%2D51g.htm*

**Department of Public Health, Essential Health Services regulations:**
*www.state.ma.us/dph/dhcq/essreg1.htm*

**Massachusetts Health Data Consortium:**
*www.mahealthdata.org*

## MEETING FACILITATION AND DECISION-MAKING

***How to Make Meetings Work,*** Michael Doyle, David Straus (Berkeley PubGroup, 1993).

***Facilitator's Guide to Participatory Decision-Making,*** Sam Kaner, Lenny Lind, Catherine Toldi, Sarah Fisk, Duane Berger (New Society Publishers, 1996).

***Building United Judgment: A Handbook for Consensus Decision-Making,*** Center for Conflict Resolution. (Available at *store.ic.org/products/building-united-judgment.html*)

***A Manual for Group Facilitators,*** Center for Conflict Resolution. (Available at *store.ic.org/products/manual-group-facilitators.html*)

## GETTING MEDIA COVERAGE

**ImPRESSIVE, Media Tip Sheets,** *www.familiesusa.org/pubs/pubs_tools.htm.* Very useful series of tip sheets aimed at helping advocacy groups work with a variety of media to get their message out successfully. Published regularly.

**SPIN WORKS! A Media Guidebook for the Rest of Us,** The SPIN Project (Strategic Press Information Network), *www.spinproject.org*.

This website has a host of useful resources for activists seeking press coverage.)

***Prime Time Activism: Media Strategies for Organizing,*** Charlotte Ryan (South End Press, 1991).

## ORGANIZATIONAL GROWTH AND PLANNING

***Grassroots Nonprofit Leadership: A Guide for Organizations in Changing Times,*** Lakey, Lakey, Napier, and Robinson (New Society Publishers, 1995).

## ORGANIZING MANUALS AND PRIMERS

***Community Organizing and Community Building for Health,*** Meredith Minkler (Ed.) (Rutgers University Press, 1997).

***Bridging the Class Divide and Other Lessons for Grassroots Organizing,*** Linda Stout (Beacon Press, 1997).

***The Activist's Handbook: A Primer,*** Randy Shaw (University of California, 2001).

***Organizing for Social Change: Midwest Academy: Manual for Activists,*** Kimberley A. Bobo, Jackie Kendall, Steve Max (Seven Locks Press, 2001).

***Rules for Radicals: A Practical Primer for Realistic Radicals,*** Saul D. Alinsky (Vintage Books, 1989).

***Reveille for Radicals,*** Saul Alinsky (Random House, 1991).

**"When Your Community Hospital Goes Up for Sale:** A Guide to Understanding the Sale and Conversion of Not-for-Profit Hospitals to For-Profit Corporations and What

You Can Do About It," Volunteer Trustees. (Available at *www.volunteertrustees.org/conver.html*)

## PUBLIC HEARINGS

**"How to Win at Public Hearings,"** Center for Health, Environment and Justice, 703-237-2249. (Their website is a good source for organizing tips in general: *www.chej.org/toolbox/*)

**"Making the Most of Public Hearings,"** Friends of the Earth. (Available at *www.foe.org/site1/ptp/guide/organize/hearings.html)*

**"A Guide to Organizing Community Forums,"** Community Catalyst. (Available at *www.communitycatalyst.org/index.php3?fldID=4)*

## COALITION BUILDING

**"Strength in Numbers: Guide to Building Community Coalitions,"** Community Catalyst, 2003. (Available at *www.communitycatalyst.org/index.php3?fldID=4*)

***From the Ground Up! A Workbook on Coalition Building & Community Development,*** Gillian Kaye, Tom Wolff (AHEC/Community Partners, 1997).

***The Spirit of the Coalition,*** Bill Berkowitz, Tom Wolff (APHA, 1999).

***A Guide to Coalition Building,*** Janice Forsythe, Canadian Council on Smoking and Health, March 15, 1997. (Available at w*ww.cypresscon.com/coalition.html*)

"**Community How-To Guide on Coalition-Building,"** National Transportation Safety Administration**.** (Available at *www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book1_CoalitionBldg.html*)

**AHEC/Community Partners Coalition Building Guides and Tipsheets**. Available at *www.ahecpartners.org/resources/hcm/materials.shtml*)

***States of Health. Building Coalitions: Lessons from the Alliance for a Healthy New England*****,** Community Catalyst, Volume 11, No. 3, Winter 2002.

## RESOURCES AND TOOLS ON HEALTH POLICY AND HEALTH CARE ACCESS

**Community Catalyst –** *www.communitycatalyst.org,* (617) 338-6035

**Families USA –** *www.familiesusa.org,* (202) 628-3030

**National Health Law Program –** *www.healthlaw.org,* (310) 204-6010

**The Access Project –** *www.accessproject.org,* (617) 654-9911

## OTHER WEBSITES CITED

**Midwest Academy** – *www.midwestacademy.com*

**United States Census** – *www.census.gov*