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Untold Perspectives: The Impact of the Closure of a Health Institution in a Black Community in North St. Louis County

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Untold Perspectives: The Impact of the Closure of a Health Institution in a Black Community in North St. Louis County

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Abstract

Based on the literature of social determinants of health, health equity, and anchor institutions, it is evident that hospitals have a role to play in ensuring the health of their community. However, our understanding of the impact of hospital closures is limited, especially when it comes to Black communities. The purpose of this study is to examine the relationship of the closure of the Normandy Osteopathic Hospital to the social determinants of health—specifically access to care and economic stability as it relates to income and wealth generation—for a Black community in one near-North suburb of St. Louis. Ten individuals with a connection to the Normandy Osteopathic Hospital were interviewed using qualitative methods and an oral history protocol. Data was coded and analyzed using thematic analysis. Findings showed layers of disinvestment over time through national and local health care management decisions. Findings also showed that the hospital closure not only had an impact on access to health care, but also on community self-worth and economic wellbeing. As a result of these findings, policy implications and recommendations are explored.

Keywords: racial equity, health equity, social determinants of health, health access, economic stability, oral history, anchor institutions

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“Dad, your light will shine through me, and the work done to create equity and equality for the least of these.”

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Chapter 1

Local health institutions play an integral role in the health and wealth of local communities. Local hospitals can be one of the only sources of health care, especially for vulnerable communities (Bhatt & Bathija, 2018). Communities with hospitals are linked with increased resilience and reduced patient mortalities during a disaster (Shen & Hsia, 2012), and hospitals provide benefits to their region in the form of purchasing goods and services. In 2016, these benefits were \$157 billion across the U.S. (American Hospital Association, 2017). Beyond health outcomes, local hospitals also influence their region's economic footprint. While we do not have data for the St. Louis region specifically, in a study by the Missouri Hospital Association in 2019, "nearly 310,000 jobs in Missouri are attributable to either hospitals' day-to-day operations or capital spending. These jobs delivered more than \$19.3 billion in labor income, wages and benefits to Missourians" (Missouri Hospital Association, 2019, p. 4).

Access to healthcare is an important factor in people's overall health. According to Healthy People 2020 (a national initiative to promote health), access to care can help prevent diseases, illness, and disabilities, and to facilitate the detection and treatment of medical conditions. Barriers to care, such as inadequate transportation and lack of insurance, can lead to unmet health needs, delays in care, reduced preventative measures, and increased financial burden (Office of Disease Prevention and Health Promotion, n.d., Healthy People 2020). Local health care options are a key component to ensuring that communities have access to care. In a systematic review of health care outcomes, *proximity to care* was identified as an enabling factor for better health outcomes in 77% of the 108 studies that looked at travel distance to care (Kelly et al., 2016). However,

many communities lack the care providers they need to ensure that their health needs are being met. There were 7,679 federally designated primary care Health Professional Shortage Areas in the U.S. in 2017 (U.S. Department of Health and Human Services, 2017). A health professional shortage area can be based on geography, specific populations or specific facilities. The federal government, through the Health Resources and Services Administration, makes these designations and they encompass physical health services, mental health services and dental services.

Racial inequities create numerous barriers to health, opportunity, and success. These inequities have contributed to significant health gaps in the United States (National Academies of Sciences, Engineering, and Medicine, 2017; Purnell et al., 2018). There are many different ways that health inequities are seen in the United States; one of them is inequitable access to care.

Overarching systematic patterns of racial bias have plagued communities of color, leaving deep-rooted problems caused by a variety of inequitable conditions, especially income inequality and a lack of economic growth. Inequitable economic and public policy has been a factor leading to contrasting conditions. For instance, redlining as a structurally racist policy has been linked with disparate health outcomes throughout the country (Nardone et al., 2020). It could be argued that St. Louis is a case study in racially inequitable housing policies, including redlining, housing covenants, and housing contracts, as evidenced in Richard Rothstein's *The Color of Law* (2017) and his Economic Policy Institute paper, "The Making of Ferguson" (2014). These housing inequities are linked with regional health inequities, as exhibited in the "For the Sake of

All" study which found that White St. Louisans have an 18 year longer life expectancy than Black St. Louisans (Purnell et al., 2018).

Similarly, a study of maternal and child health outcomes showed that Black infants are two times more likely to die before they turn a year old than White babies in St. Louis County (St. Louis County Department of Health, 2019). Eight zip codes in North St. Louis County, home to large percentages of Black residents, were found to have higher rates of breast cancer and leukemia, rates that were highest among Black women. Further, in St. Louis City, Black children are almost twice as likely as White children to have high lead levels (St. Louis City Department of Health, n.d.). Moreover, the region has seen disparities in the rates of COVID-19 diagnosis, with higher case rates in predominantly Black communities as compared to predominantly non-Black communities (Olmos, 2020). Similar statistics are evident in other parts of the United States. For instance, by the beginning of 2021, COVID-19 infections of Black Americans were three times higher than that of Whites and twice as many Black people died from the virus (Brooks, 2021). The St. Louis County Department of Public Health released a report on October 4, 2021, showing that after heart disease and cancer, COVID-19 was the third leading cause of death in the County in 2020 (Tutlam et al., 2021). Of the 11,958 deaths in 2021 in St. Louis County, 11% or over 1,300 deaths were due to COVID-19. Because of the pandemic, the average life expectancy of people in both the state of Missouri and in St. Louis County decreased, falling 2.1 years from 77.4 to 75.3 years in Missouri and by 2.3 years, from 79 to 76.7, in the County. The disparities along racial lines in life expectancy are clear in the data. An article in the *St. Louis Post Dispatch* that focused on this report noted:

But the drop was even more pronounced for Black residents, as COVID-19 exacerbated inequities in income and access to health and other public services between predominantly Black north St. Louis County and other parts of the county, the report said. Chronic health conditions like heart disease and diabetes that made COVID-19 more dangerous are also more prevalent among Black residents. (Benchaabane, 2021, para. 8)

Health disparities and health care access are connected. An evaluation done by the St. Louis Regional Health Commission (2019) suggested that people who are uninsured or who have coverage under the state of Missouri's Medicaid program have challenges accessing healthcare in St. Louis. Approximately 67% of individuals in these groups identify as Black, indicating that Black people are most impacted by the barriers to accessing healthcare. According to the study:

Some barriers may include but are not limited to: appointment availability; wait times and operational hours; provider capacity; transportation and distance to providers; disease severity; health insurance; affordability and paperwork/processes for financial assistance; interpretation services and materials for non-English speakers; cross-cultural differences; and health system navigation. (St. Louis Regional Health Commission, 2019, p. 4)

In addition to a lack of healthcare access due to these constraints, Black people across the nation have little access to Black physicians and nurses. According to the Association of American Medical Colleges, only 5% of American physicians identify as Black or African-American (Association of American Medical Colleges, 2019) while U.S. Census data shows that 13% of the people in the U.S. identify as Black (Ly, 2021).

Studies show that Black patients have more trust in Black doctors and that they “have better health outcomes and routinely agree to more—and more invasive— health tests and interventions when they’re seen by Black physicians” (Brooks, 2021, p. 1). Studies also show that when pregnant Black women have a Black health care provider, they have a lower rate of maternal mortality and their babies are more likely to survive (Brooks, 2021; Greenwood et al., 2020). Other studies show that Black providers provide more effective care leading to better health outcomes for Black men (Alsan et al., 2018). This evidence points to the importance of access to health care options and particularly access to Black physicians and other Black healthcare providers.

African Americans' distrust of the healthcare system is rooted in historic racist practices of the scientific medical community. During the time of slavery in the United States when Black people were considered property and had no rights to their own bodies, they were used in human experimentation. As one example, Dr. Thomas Hamilton placed an enslaved man in a pit constructed in such a way as to allow only the man’s head above ground. The pit was heated to see how hot it could get before the man passed out. Hamilton used this technique to decide how long slaves could work in the fields (Ayeh, 2016). Even after the abolition of slavery, Black people were used in research without their consent. For instance, in 1951, Henrietta Lacks went to John Hopkins Hospital because she had been experiencing some vaginal bleeding. During that era, John Hopkins Hospital was one of a few hospitals that offered medical care for poor African Americans. Upon examination, Dr. Howard Jones discovered a malignant cervical tumor. He took a piece of her tumor without permission to study. Eventually Ms. Lacks died. Dr. Jones shared the tissue sample taken from Ms. Lacks for research without

the knowledge or consent of the Lacks family. The cells known as HeLa cells were used in research on cancer and other medical research for decades after (Skloot, 2000).

Another well-known example of human experimentation on Black people is the Tuskegee Syphilis Study. This experiment was a government sponsored project and included four hundred African American men from 1932-1972 to research the effects of untreated syphilis. Unknown to them, there was treatment available, but it was not provided to these men. Over one hundred died during this experiment program.

After the abuses of the Tuskegee Syphilis Study were revealed, the federal government strengthened regulations to protect the subjects of human experimentation. These increased safeguards, however, have not erased many African Americans' fear that they would be abused in the name of medical research. (Gamble, 1993, p. 35)

It is evident that a variety of structural and systemic inequities have led to disparate health outcomes for Black communities. In this study, we aim to understand better the historical context of access to care, and the potential policies and roles that can address these ongoing disparate outcomes in the St. Louis community through the lens of one hospital closure in North County St. Louis and the related impact on the surrounding community. The dissertation team believes that research links inequities to larger issues of health equity, social determinants of health, and the role of medical providers in communities.

Health Equity

Health equity has many definitions. It can be defined as when all people have “the opportunity to attain their full health potential and no one is disadvantaged from

achieving this potential because of their social position or other socially determined circumstance” (Centers for Disease Control and Prevention, n.d., Health Equity section). Simply, “attainment of the highest level of health for all people” is the definition of health equity used by the U.S. Department of Health and Human Services (Office of Disease Prevention and Health Promotion, 2020, Disparities section). There are several definitions for health equity listed on the Illinois Academy of Family Physicians website posted on September 30, 2020.

- Health equity is used to describe differences in health that are unfair and unjust” notes David R. Williams, PhD, MPH; Professor of Public Health at Harvard T.H. Chan School of Public Health.
- Equity is “the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means stratification” according to the World Health Organization.
- Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment” states the CDC. (Illinois Academy of Family Physicians, 2020, Definitions of Health Equity section)

Social Determinants of Health

Social determinants of health describe the conditions that lead to the health of communities and individuals (Commission on Social Determinants of Health, 2008). These conditions are economic and social and reflect the amount of money, power, and resources that people and communities have (Weida et al., 2020). While social

determinants of health are not the only factors affecting an individual's health (other factors include genetics, behavior, and environment), they play a significant role, especially given the historical systemic marginalization of Black and Brown people (Commission on Social Determinants of Health, 2008). In Ruqaiyah Yearby's publication, "Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause," she asserts:

The current public health (SDOH framework) and legal (anti-discrimination laws) responses are inadequate because they focus only on a specific action or perpetrator rather than the system of racism. This legitimizes the existing social system of racism, leaving in place a racial hierarchy that is reinforced by social norms and institutional practices. To achieve racial equity—to achieve, that is, a new reality where race can no longer predict life outcomes and where outcomes for all groups are improved—governments must dismantle the system of racism. (Yearby, 2020, p. 8)

Yearby's quote points to the need for social change agents to focus on changing the interlocking policies, procedures, norms, and cultures that keep racism built into the way that institutions do business, rather than focusing on the needs of individuals or specific communities.

Experiences like poverty, limited access to high-quality care, poor early childhood education, and discrimination all negatively affect the social determinants of health (Braveman & Gottlieb, 2014). Lower positions in the social, economic, and political hierarchies are linked with poorer outcomes, and these conditions disproportionately affect Black and Brown individuals and communities (National Academies of Sciences,

Engineering, and Medicine, 2017; Purnell et al., 2018). Research continues to highlight factors that are not directly in an individual's control, such as neighborhood conditions, education, and childhood experiences, among others, as critical influencers of health (Bharmal et al., 2015; Braveman et al., 2011).

Anchor Institutions: Hospitals as Economic Drivers in Communities

Studies show that health systems can play a significant role in communities, not only as a direct health care provider to residents, but also as a key economic engine and source of community pride and connection. In several ways, hospitals can be considered anchor institutions (Schwarz, 2017) based on their general stability within a community and their role as employer, community builder, data manager, and direct service provider.

Health-related institutions tie directly to social determinants of health because they address the direct health needs of a community, educational opportunities, economic impact, community cohesiveness, and the built environment. Recent literature explores how hospitals can be more intentional in recognizing and acting on their role as an anchor in the community. Norris and Howard (2016) identify The Healthcare Anchor Network and the Democracy Collaborative as two entities that advocate that hospitals use their purchasing power to promote community health and prosperity. Dave et al. (2021) assert that hospitals are uniquely situated as anchor institutions to address social determinants of health and anti-racism within their system and within the community. However, the contemporary understanding of the anchor institution's role is posited on the relative stability and permanence of these large institutions. Less is known about the effects when an institution that served as an anchor leaves a community. For instance, what are the

challenges in accessing healthcare services and how are barriers addressed? Further, what are the economic repercussions in the community after a hospital leaves? Another question is how the residents feel about the closure of the institution and how they see it affecting their understanding of their community.

Problem Statement

Betty Reid Soskin, who was the oldest active ranger in the National Park Service until retiring in March of 2022, was known for saying, “What gets remembered is determined by who is in the room doing the remembering” (Page, 2021, p. 1). Currently, there is very little information readily accessible that provides a glimpse into the history of the Normandy Osteopathic Hospital which was located in Normandy, Missouri; it is a history that remains difficult to find. What we have discovered is that the hospital served the community from 1948 through January 2000 offering a complete array of medical services to the area. The hospital attracted people to live in the surrounding neighborhoods and employed many of those people. It also was a community space where people gathered and was a source of pride for area residents. During the 50-year timespan that the hospital served the community, there were many societal changes including the demographic makeup of the area. Residents changed from predominantly White to predominantly Black. Nevertheless, even with the demographic changes, the hospital continued to be a service for community residents. What is not clear, and where there is a gap in our knowledge, is the effects of the loss of the hospital on the health and economic wellbeing of the Black community living in and near Normandy.

Some other hospitals that closed during the latter years of the 20th century have been researched extensively to understand how the presence of the hospital and its

subsequent closure affected the community. One in particular, Homer G. Phillips Hospital, a public hospital in the City of St. Louis, is an example of what was an anchor institution in the Black community in the 20th century. “Homer G Phillips Hospital was an ‘economic anchor’ for the community by giving employment to hundreds in the Homer G. Phillips community, and training approximately 20% of black physicians prior to 1960” (Johnson, 2003, p. 487). A city report by Pesch and Smith released in 1976 cited Phillips Hospital as a “principal resource to the local and national Black community . . . an anchor institution . . . providing economic resources as well as community services,” and “a major resource for the education of American Blacks” (Kirouac-Fram, 2010, p. 600).

In a personal communication to Paul McKee published in the *St. Louis American*, Dr. Will Ross wrote:

The legendary Homer G. Phillips Hospital in the Ville neighborhood was a cultural icon, the pride of not just North St. Louis but our entire community. It achieved the status of one of the most influential black hospitals in the country during its tenure from 1937 to 1979. It was a magnificent edifice, an architectural masterpiece, and a place of physical, mental, and spiritual healing for generations of African American St. Louisans. It trained the best and brightest physicians, nurses, and allied health professionals in the country. (King, 2020, paragraph 22)

In a basic search of hospital closures in Black communities in St. Louis, Homer G. Phillips Hospital is prevalent in the results. However, information about the closure of Normandy Osteopathic Hospital and the subsequent effects of closure of this hospital are hard to find. While limited, we were able to find one newspaper article detailing the

closure of the hospital specifically focused on the disinvestment of the Texas company, HealthPlus Corporation, which owed St. Louis creditors over \$2 million at the time of closing (Manning, 2000). An earlier newspaper article focused on hospital closure within a larger context of medical displacement as institutions began moving out of North St. Louis (Webb, 1976). Despite limited information, both articles highlight disinvestment in medical care that specifically affected Black residents of North St. Louis City and County.

Based on the literature of social determinants of health, health equity, and anchor institutions, it is evident that hospitals have a role to play in ensuring the health of their community. Increasing our knowledge and documenting a qualitative understanding of the impact of this hospital closure can help us better understand the historical context directly in the Normandy footprint. This missing story of the Normandy Osteopathic Hospital is like a missing piece of a puzzle. This information, combined with that which has been gained from research on other hospitals in Black communities like Homer G. Phillips Hospital, can be used to identify trends within other Black communities that experienced the loss of medical institutions and providers in the St. Louis region.

Purpose Statement

The purpose of this study is to use oral histories to examine the relationship of the closure of the Normandy Osteopathic Hospital to the social determinants of health—specifically access to care as well as to economic stability in income and wealth generation—for the Black community in one near-North suburb of St. Louis. We aim to tell a portion of what we believe is an untold story by exploring what happens when a

health-related institution in a community with a significant Black population closes and how does this closure affect health equity and economic wellbeing in a community.

This purpose comes out of our research team's experience in the following areas: community and public health, economic development, community development, and anchor institution work. Recognizing that a range of structural inequalities and socioeconomic drivers affect access to healthcare as well as income and wealth generation, we are particularly interested in how community voice is included in decision making that affects members of a community. As noted, there is a lack of information about the hospital closure that our team selected. (Perhaps this lack of available information highlights a disparity in and of itself in which community stories are told, but that is beyond the scope of our dissertation.) In light of the findings, we will consider what lessons can be learned from this history to inform future policymaking and anchor institution efforts in Black communities. We will also consider such questions as, how can we better understand the impact of the closure on the community and prevent further erosion of health care services in the future? What impact would community voice and accountability (e.g., advisory boards, advocacy groups) have in future scenarios that are similar? Additionally, connecting with Walter Johnson's review of St. Louis in *The Broken Heart of America* (Johnson, 2020), how do examples in St. Louis history inform our understanding of our nation's trajectory overall?

Research Question

Our research question is, "What has been the effect of the closure of the Normandy Osteopathic Hospital on access to medical care and on economic stability in income and wealth generation of Black residents of the Normandy municipality and

bordering communities in St. Louis County?” Our team selected this research question because we are interested in the social determinants of health and their role in addressing disparities and improving Black communities. Social determinants of health describe the conditions that lead to the health of communities and individuals (Commission on Social Determinants of Health, 2008). Though there are several different social determinants that affect health outcomes, this research team is focusing on these specifically 1) access to health systems and services, and 2) income and wealth generation (which we, the researchers for this study, also refer to as economic stability). Our aim is to explore the relationship between the closure of the Normandy Osteopathic Hospital and subsequent effects on the health and wellbeing of Black residents in the community.

Chapter 2: Literature Review

In the late 20th century, St. Louis experienced a series of hospital closures due to a range of factors including reduced funding. In 1979, Homer G. Phillips, a long-standing pillar serving the Black community in St. Louis, closed. Kirouac-Fram (2010) details the varied reactions to this closure, underscoring the differences in the Black community. According to Kirouac-Fram (2010), reactions included marches, protests, and demands over a period of more than ten years to maintain the hospital as a key economic anchor in the community, and to continue to address needed access both in terms of distance to care as well as access to Black medical providers. However, the Black community also included reactions of indifference or even support from Black residents who saw the hospital as a vestige of segregation. In 1985, St. Louis City Hospital closed; in 1986, St. Louis County Public Hospital closed; and in 1997 the last publicly funded hospital, St. Louis Regional Medical Center, closed. In 2000, the Normandy Osteopathic Hospital, located in an inner ring suburb of St. Louis County in Normandy, Missouri, also closed.

Considering access as both the concrete components (distance to care, wait times, hours of operation) as well as the subjective components (cultural responsiveness, unbiased care), the loss of medical facilities such as Homer G. Phillips Hospital, St. Louis City Hospital, and St. Louis Regional Medical Center introduced medical deserts in St. Louis. This was recognized by Ernest Calloway, an urban affairs instructor at St. Louis University involved in a coalition to save the hospital, who said, “Without Homer G., north St. Louis will become a health desert” (Webb, 1976, para. 10). Similarly, the closure of Normandy Hospital left yet another medical desert in what had become a

predominantly Black community with detrimental effects on those residents living in and around Normandy, contributing to the increasing health inequities across the region.

According to the St. Louis Regional Health Commission, after these closures, “the region faced a fiscal crisis jeopardizing the health care safety net, which provides access to essential health care services for people experiencing barriers to appropriate, timely, affordable, and continuous health services” (St. Louis Regional Health Commission, n.d., History section). Since then, the Regional Health Commission, alongside public and private partners, has stepped in with several initiatives in an attempt to ensure that St. Louis’ underserved populations have access to high-quality care. Some of these safety net health care provider institutions include Affinia Health, BJC clinics, Casa de Salud, SSM, and SLUCare, among a list of others (St. Louis Regional Health Commission, 2019, p. 21).

Bonnie Castillo, executive director of National Nurses United, a national nurses’ union, stated that hospital closures “have a disproportionate impact on certain patient populations. Urban hospital closures are more apt to happen in racially segregated communities and especially in African American neighborhoods,” she says. “The effects on these communities are devastating, as research shows that nationally urban African Americans receive their primary and other care at a hospital, compared to one in six for whites” (Williams, 2019, p. 1).

Private hospitals that have continued to provide service in the region have also participated in responding to community health priorities. One way that some do this is by recognizing their role as an anchor institution. “Anchor institutions— large, place-based establishments—invest in their communities as a way of doing business” (Koh et

al., 2019, p. 309). These include *anchor meds* which are generally hospitals and other health systems that address social determinants of health in their community through economic development, local hiring and procurement, access to care, education, and community building. These anchors have generated significant attention and activity over the past decade. However, there has been little research on the effectiveness of anchor meds. A study that attempted to begin this conversation included fourteen key informant interviews to create an early framework for best practices emerging from anchor practices. These included local hiring, local sourcing, place-based investments, and evaluation (Koh et al., 2020). One caveat that the Koh team noted to the effectiveness of anchor hospitals is “willingness to commit years of time engaging key internal and external audiences because ‘change happens at the speed of trust’” and a key challenge is “overcoming long standing mistrust between institutions and community members” (Koh et al., 2020, p. 314).

Literature on anchor institutions focuses on the potential for anchor institutions to be agents of change in the community (Dave et al., 2021; Dubb et al., 2013; Guenther et al., 2019; Koh et al., 2020; National Academies of Sciences, Engineering, and Medicine, 2017), but there are gaps in the literature on the outcomes when an anchor institution closes or departs. Homer G. Phillips was an original anchor, stable and rooted in the community, providing both healthcare as well as jobs, training and stability for the area. The story of its closure and the repercussions for the community have relevance for today’s anchor institutions that are looking to build trust and to have community impact.

According to Franz et al., hospitals “will increasingly be characterized by the actions [they take] to address the needs of surrounding neighborhoods” (Franz et al.,

2019, p. 7). Indeed, the future of medical institutions will continue to be tied up with the communities surrounding them (Harkavey & Zuckerman, 1999). Therefore, it would serve current and aspiring anchor institutions to learn the lessons of institutions that have come before. To be truly committed as an anchor, they must also be cognizant of how a change in their service or potential closure might affect the community in which they reside and make every effort to alleviate any of the negative effects on the health and wellbeing in and of the community that might result. Though it is not clear if Normandy Osteopathic Hospital would have been considered an anchor institution in the sense of being strategic with hiring practices, local procurement and engagement with the community, insights into the closure of the institution can be informative for future anchors.

Conceptual Model

Closely linked to the definition of health equity are the social determinants of health. Social determinants of health describe the conditions that lead to the health of communities and individuals (Commission on Social Determinants of Health, 2008). These conditions are economic and social and reflect the amount of money, power, and resources held by people and communities.

Inequitable social determinants of health are a result of racially biased historical policies and practices on which systems were built. Therefore, systemic solutions are needed to address these inequitable conditions. “A growing body of research highlights the importance of upstream factors that influence health and the need for policy interventions to address those factors” (Centers for Disease Control and Prevention, n.d., NCHHSTP Social Determinants of Health page), with upstream factors being policy,

funding and cultural influences. Forward through Ferguson, a St. Louis based nonprofit organization working toward racial equity, has adopted the following definition of systems change as a “fundamental change in policies, processes, relationships, resources and power structures, as well as, deeply held values and norms” (Gopal & Kania, 2015, p. 1). Moreover, systems change theorists stress that “systems change involves shifting the conditions that hold the problem in place” (Kania et al., 2018, p. 3).

Though healthcare needs vary from community to community, the recommendation from the American Hospitals Association task force is that:

Access to a baseline level of high-quality, safe, and effective services should be preserved and protected within all communities. These essential health care services are: primary care, psychiatric and substance use treatment services, emergency department and observation care, prenatal care, transportation, diagnostic services, home care, dentistry services, and a robust referral structure to provide all individuals in the community with access to the full array of health care services. (Bhatt & Bathija, 2018, p. 1272)

The 2017 *Communities in Action: Pathways to Health Equity* report from the National Academies of Sciences, Engineering, and Medicine states:

Health inequity...arises from social, economic, environmental, and structural disparities that contribute to intergroup differences in health outcomes both within and between societies.... The report identifies two main clusters of root causes of health inequity. The first is the intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender

expression, and other dimensions of individual and group identity...The second, and more fundamental root cause of health inequity, is the unequal allocation of power and resources—including goods, services, and societal attention—which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health. (National Academies of Sciences, Engineering, and Medicine, 2017, p. 99)

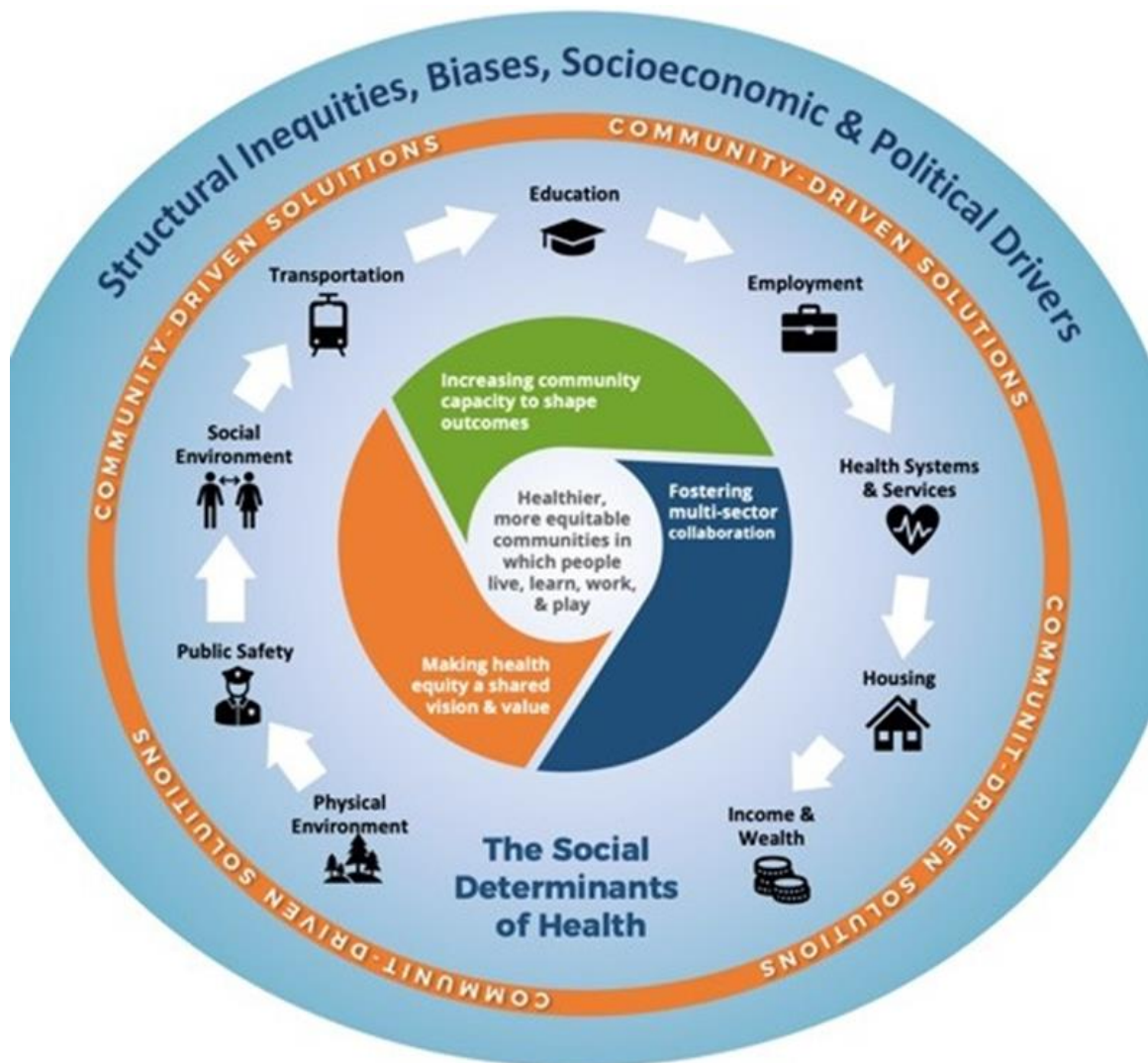
This report includes a conceptual model for community-based solutions that promote health equity, which resonates with the understanding of this research team.

In the conceptual model (Figure 1), the outermost circle focuses on structural inequities. Being structural means that they are integrated into the foundations of society, as we know it.

Structural inequities encompass policy, law, governance, and culture and refer to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains. These inequities produce systematic disadvantages, which lead to the inequitable experience of the social determinants of health... and ultimately shape health outcomes. (National Academies of Sciences, Engineering and Medicine, 2017, p. 103)

Figure 1

Conceptual Model for Community-Based Solutions to Promote Health Equity



Note. This conceptual model for community-based solutions to promote health equity is an edited version of the one from the National Academies of Sciences, Engineering, and Medicine, 2017

Outcomes of experiences in the social determinants of health affect a person’s entire life, influencing how they interact in society and their overall health. Structural inequities were developed through years of discriminatory and exclusionary policies and

practices that created inequitable access, security and wealth. Understanding how this historic bias continues to permeate peoples' perceptions and interactions in society is key to developing community driven solutions (the next circle in the model) to alleviate health inequities. These community-driven research solutions require an understanding of the data available for the locality, and specifically for the nine identified social determinants of health, as well as collaboration and focus. Table 1 provides a description of each of the social determinants of health that appear in the concept model.

Table 1

Overview of Social Determinants of Health

| Determinant of Health | Explanation |
|------------------------------|---|
| Education | The access or lack of access to learning opportunities and literacy development for all ages which effectively serves all learners. Education is a process and a product: as a process, education occurs at home, in school, and in the community. As a product, an education is the sum of knowledge, skills, and capacities (i.e., intellectual, socio-emotional, physical, productive, and interactive) acquired through formal and experiential learning. Educational attainment is a dynamic, ever-evolving array of knowledge, skills, and capacities. Education can influence health in many ways. Educational attainment can influence health knowledge and behaviors, employment and income, and social and psychological factors, such as the sense of control, social standing, and social networks. |
| Income and Wealth | Income is the amount of money earned in a single year from employment, government assistance, retirement and pension payments, and interest or dividends from investments or other assets. Income can fluctuate greatly from year to year, depending on life stage and employment status. Wealth, or economic assets accumulated over time, is calculated by subtracting outstanding debts and liabilities from the cash value of currently owned assets—such as houses, land, cars, |

| | |
|------------------------------------|---|
| | <p>savings accounts, pension plans, stocks and other financial investments, and businesses.</p> <p>Wealth measured at a single point in time may provide a more complete picture of a person's economic resources. Access to financial resources, be it income or wealth, affects health by safeguarding individuals against large medical bills while also making available more preventive health measures such as access to healthy neighborhoods, homes, land uses, and parks.</p> |
| Employment | <p>The level or absence of adequate participation in a job or the workforce, including occupation, unemployment, and underemployment. Work influences health not only by exposing employees to physical environments, but also by providing a setting where healthy activities and behaviors can be promoted (An et al., 2011). The features of a worksite, the nature of the work, and how the work is organized can affect worker mental and physical health (Clougherty et al., 2010). Many Americans also obtain health insurance through their workplace, another potential impact on health and wellbeing. Health also affects one's ability to maintain stable employment (Davis et al., 2016; Goodman, 2015). For most working adults, employment is the main source of income, providing access to homes, neighborhoods, and other goods and services that promote health.</p> |
| Health Systems and Services | <p>The access or lack of access to effective, affordable, culturally and linguistically appropriate, and respectful preventative care, chronic disease management, emergency services, mental health services, and dental care and the promotion of better community services and community conditions that promote health over the lifespan, including population health outcomes. It also refers to a paradigm shift that reflects <i>health</i> care over <i>sick</i> care and that promotes prevention.</p> |
| Housing | <p>The availability or lack of availability of high-quality, safe, and affordable housing that is accessible for residents with mixed income levels. Housing also refers to the density within a housing unit and within a geographic area, as well as the overall level of segregation/diversity in an area based on racial and ethnic and/or socioeconomic status. Housing affects health because of the physical conditions within homes, the conditions in the neighborhoods surrounding homes,</p> |

| | |
|-----------------------------|---|
| | and housing affordability, which affects the overall ability of families to make healthy choices. |
| Physical Environment | The physical environment reflects the place, including the human-made physical components, design, permitted use of space, and the natural environment. It includes, for example, transportation/getting around, what's sold and how it's promoted, parks and open space, look and feel, air/water/soil, and arts and cultural expression. |
| Transportation | Transportation consists of the network, services, and infrastructure necessary for residents to get from one place to another. If designed and maintained properly, transportation promotes safe mobility and is accessible to all residents, regardless of geographic location, age or disability status. Unsafe transportation can result in unintentional injuries or death. Access or lack of access to quality transportation at the community level affects opportunity for employment and vital services such as health care, education, and social services. Active transportation—the promotion of walking and cycling for transportation, complemented by public transportation or any other active mode—is a form of transportation that reduces environmental barriers to physical activity and promotes positive health outcomes. Transportation can also have negative environmental impacts, such as air pollution, which can affect health. |
| Social Environment | The social environment, sometimes referred to as social capital, reflects the individuals, families, and businesses within a community, the interactions and kinship ties between them, and norms and culture. It also includes social networks and trust as well as civic participation and willingness to act for the common good. |
| Public Safety | Public safety refers to the safety and protection of the general public. Here it is characterized by the absence of violence in public settings and the role of the justice system. Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological or emotional harm, maldevelopment or deprivation, and trauma from actual and/or threatened, witnessed and/or experienced violence. |

Note. This table is from the National Academies of Sciences, Engineering, and Medicine, 2017, pp. 118-120

The next inner circle in the conceptual model is communities' actions to address health equity. These actions include 1) creating a shared vision and value of health equity, 2) increasing community capacity to shape health outcomes, and 3) fostering multi-sector collaboration. This ring focuses on three areas of action that have a research base linked to improved health outcomes, as outlined in the National Academies of Sciences, Engineering, and Medicine report (2017). A multi-sector approach is required to address all the challenges that result in health inequities. These sectors include businesses, health and government institutions, as well as nonprofit and faith-based organizations. The innermost circle is the desired outcome—healthier, more equitable communities in which individuals and families live, learn, work and play.

We, the research team for this study, are utilizing this conceptual model as a framework to examine the experiences of people connected to and affected by the closure of the Normandy Osteopathic Hospital. Our focus is on learning the history and sharing the experiences of those impacted by the closure of Normandy Osteopathic Hospital and subsequent loss of health care resources available in Normandy. This includes better understanding any related inequities in income and wealth that followed the closure of this medical institution and the associated healthcare services. In doing so, we hope our research will shed light on ways to increase health equity in the future, through the activation of community voice and accountability, cross-sector advocacy, and a common vision for community health, wealth, and social justice.

Research Location and Background

The community of focus for this research, Normandy, Missouri, is located in an inner-ring suburb in North St. Louis County and was home to the Normandy Osteopathic

Hospital. Unlike Homer G. Phillips Hospital, there is very little information readily available on the Normandy Osteopathic Hospital, which also went by the names Normandy Community Hospital and Deaconess North. Archival records on the hospital are sparse.

The racial composition of the community in and around Normandy changed significantly from the time the hospital was first opening in the mid-20th century to its final closing almost 50 years later. According to census data, in 1950 the City of Normandy had 2,300 residents. During the 1950s, the 63121 zip code in which the Normandy Osteopathic Hospital was located comprised 14 municipalities with 33,097 residents (U.S. Department of Commerce, 1950). There is little census data on race at that time available, but the Normandy School District during those years was all White. According to a Civil Rights report from January 1981 that was titled "School Desegregation in St. Louis and Kansas City Areas Metropolitan Interdistrict Options," it was not until 1954 that Black students who lived in school districts outside St. Louis City, Webster Groves, Kirkwood, and Kinloch went to school in their districts for secondary education. Instead, they "were bused out of the district for their high school education" (Missouri Advisory Committee to the United States on Civil Rights, 1981, p. 3). The report further shows that by 1978, the Normandy School District was about 75-95% minority students, having grown quickly in less than a decade from 2,800 Black students in 1970 to 6,200 in 1978. This increase reflected a significant movement of the Black population from the City of St. Louis to the county. During that period, a survey was conducted with residents living in the Normandy School District boundaries, which were mostly in Normandy. Survey results showed that:

About one-half of the people living in Normandy have moved there within the past five years. About half of these newcomers were white and half Black. As a result of the fifty-fifty flow, the racial composition had gone from 85 percent white, 15 percent black in 1970 to 70 percent white, 30% Black in 1974.

(Normandy School District Survey, 1974)

According to Census data, by 1990, Normandy was 50% Black and by 2000 when the hospital closed, in Normandy specifically, 70% of the residents were Black, which is similar to the 63121 zip code overall (68.2% were Black).

As previously noted, information on the hospital is hard to come by; however, the Missouri State Archives has archival clippings from the *St. Louis Globe Democrat* that include some references to the hospital through the years. An August 24, 1952 article noted that construction began on Normandy Osteopathic Hospital in August of 1952 for an estimated cost of \$500,000. The plan was for the hospital to have emergency services, laboratory, operating rooms and labor and delivery services. This article celebrating the construction stated that, “The hospital will be operated as a non-profit corporation governed by a lay board. A general hospital, it is staffed by 50 active local osteopathic physicians and 15 associated staff members from surrounding rural communities” (“Work Started,” 1952, para. 9).

The Normandy Historical Society did a history of Normandy in 1973 that included a brief overview of the hospital. Normandy Osteopathic Hospital was originally located at the Normandy Wedge, opening in 1948 with a 25-bed capacity. This was about a mile east of the new hospital that, in 1952, was constructed on the old Provost property at 7840 Natural Bridge Road at a cost of \$400,000 to construct with a 67-bed capacity.

The first patients were admitted to this new general acute care facility in late 1953. “On June 28, 1959, a \$1,500,000 second wing was built. This new wing increased bed capacity to 122 beds and 27 bassinets and provided space for emergency out-patient services, laboratories and operating and treatment rooms” (Normandy Historical Society, 1973, Normandy Osteopathic Hospital page). Another expansion in 1965 increased capacity to 173 beds and added classrooms, physiotherapy, occupational therapy departments, and a medical library. Not long after, another \$2,300,000 was invested in the hospital increasing bed capacity to 250. In 1972, the hospital started a complete remodel.

Interestingly, a community survey conducted in 1974 by researchers and students at the University of Missouri-St. Louis did not include any mention of the hospital, even though there had been clear investment in the facility the preceding years. Instead, in Goal III of the survey report to “Provide or Make Accessible, Services & Activities for Citizens of NMC Area,” the first objective was a Health Center. The recommended strategy was to “Investigate possible sites to provide various types of health service through St. Louis County Hospital” (Normandy School District Survey, 1974). Again, there was no mention of Normandy Osteopathic Hospital.

Even though the hospital was not noted in the Normandy School District survey, Normandy Osteopathic was a relevant resource for the community. In July 1978, Normandy Osteopathic Hospital began providing ambulance service in the Wellston Fire Protection District, as County ambulances had been the only provider serving this area since January 1977. The expectation was that service from the hospital would decrease response time to 3-5 minutes down from an average of 10 minutes for County service

(“Hospital Begins,” 1978). This provided faster access to medical care for the community.

Plans for growth and sustainability continued to be evident. Archive clippings from the *St. Louis Globe Democrat* from June 29, 1983 reported that in 1983 the Normandy Invitational Golf Tournament raised over \$40,000 for the hospital building fund that year (“Tournament Raises \$40,000,” 1983). In October of 1983, an additional \$600 was raised for the intensive care unit at a hospital celebration recognizing the hospital’s 35th anniversary (“Carnival Raises \$600,” 1983). Further, the hospital served as a community resource, offering health related classes at the hospital through the years. These included activities like summer programs for children with speech and language disorder or delays (“Normandy Hospitals,” 1984). In 1986, the hospital opened the first emergency medical residency program in Missouri (“Normandy Osteopathic,” 1986).

Other resources describe Normandy Hospital as having an emergency room, surgical, ICU-Telemetry, physical therapy, rehabilitation, and skilled nursing services. In addition, it served as a post-graduate training institution for osteopathic interns and residents. Deaconess Medical Center North took over the hospital in March 1990 as a 188-bed facility.

However, according to a *St. Louis Business Journal* article, Deaconess closed the hospital “in February 1993 due to low occupancy and financial losses. The hospital was purchased for \$8 million in 1995 by local doctors and Houston, Texas-based Styles & Styles Inc.” (Manning, 2001, para. 6). In 1997 the hospital reopened and became Normandy Community Hospital with only 80 licensed beds under the ownership and operation of Mid-America Equities Limited Partnership. In an article in the *St. Louis*

Globe Democrat titled, “Normandy Hospital Reopens, Spurs a Sense of Community,” the hospital’s new administrator, Glen Marshall, noted that because Normandy Osteopathic had been the only hospital in a five-mile radius, the closure of the hospital left a void in health care for people in the community. “The closing ended the hospital’s tradition of osteopathic teaching and training and also generated protests. Churches, physicians, elected officials, business owners and others mobilized” (Kee, 1997, para. 15). A grassroots initiative from the community spurred the reopening. However, the article also notes a report from the St. Louis Area Business Health Coalition that suggested an overabundance of hospital beds available in the region. Improvements in health technology and growth in managed care were cited as reasons why hospital admissions and length of stay had decreased over the years.

Normandy Community Hospital remained open until January 31, 2000. The emergency room saw over 1,000 patients a month at that time, but the hospital did not have contracts with many insurance companies for inpatient care. Financial loss could have been a reason for the closure, but available information does not make that clear. One newspaper article highlighted the sale of the vacant hospital to the University of Missouri-St. Louis (UMSL) in 2001. Based on the report in the *St. Louis Business Journal* (Manning, 2001), the community did not want the hospital to close because they wanted a health provider to remain in the area. Unfortunately, for them, like in St. Louis City with the closing of Homer G. Phillips, the Normandy hospital did succumb to the same fate.

After the University of Missouri-St. Louis acquired the vacated property, there were plans to renovate or build facilities and reopen the site to include UMSL health

profession schools (University of Missouri-St. Louis Master Plan, 2002). However, the process was stalled and the site fell into disrepair. A University of Missouri System memo from June 27, 2003 regarding Normandy Hospital Property cited concerns from city officials about deterioration of the hospital site. The memo called for clean up of the property so it would “cease to be an eyesore” and would help with community relations (Krawitz, 2003). UMSL requested an appropriation of \$10M from the Health and Human Services Budget in FY04 to establish a multi-purpose health clinic at the former site of the Normandy Osteopathic hospital. In the request, the university noted that with the closure of the hospital, Normandy and the surrounding communities were left without accessible health care options. In the *Needs* section of the request, it is noted that the community was suffering from economic distress with unemployment at 9.3% as compared to the rest of the St. Louis region at 4.1%. The poverty rate for the region was 7.1%, but Normandy was at close to 20%. Additionally, close to 51,000 residents relied on Medicaid for health care insurance, but fewer caregivers were accepting this form of payment (Health Sciences Complex Appropriations Request, 2004). The request was not funded. After a few years, the building which once was the Normandy Hospital was scheduled for demolition in 2007 due to safety concerns including asbestos, insulation, and construction issues (Demolition Forum, 2007).

Chapter 3: Research Methods

Introduction

The purpose of this study is to use oral histories to examine the relationship of the closure of the Normandy Osteopathic Hospital to social determinants of health—specifically access to care as well as to economics stability in income and wealth generation—for the Black community in one near-North suburb of St. Louis. The intent is to find meaning and significance in the lived experience of people who were in some way affiliated with the hospital. It is not about quantifying information or measuring and testing data as is done in quantitative research. Instead, it is about trying to understand a phenomenon. Therefore, the research team chose qualitative research as our methodological approach. Qualitative research is used when researchers seek to understand something, are open to discovering something new, and are able to spend time engaging in listening, discussing, and learning. “The literature might yield little information about the phenomena of study, and you need to learn more from participants through exploration” (Creswell, 2015, p. 16). Discovery is the key to qualitative research and the process of inquiry (Agee 2009).

Oral History as Research Design

While there seems to have been a wealth of research done on Homer G. Phillips hospital resulting in a documentary film, a dissertation thesis, and articles in numerous publications, it has been much more difficult to find information about the Normandy Osteopathic Hospital. Normandy Osteopathic Hospital, as previously noted, has a limited factual record including a brief mention in reports, and newspaper articles and brochures; however, it has been difficult to find detailed information about why it was built, why it

was closed, or how the closure affected the local community. The focus for this research is about more than just a lack of access to a nearby hospital to treat immediate health issues. This research inquiry is to help understand better how the closure of Normandy Hospital might have affected social determinants of health, as well as the long-term implications on the health and wellbeing of Black residents in the community.

From the currently available sources, it is difficult to understand the impact of the closure of the hospital on members of the community and how that affected community health. However, there are still people in the area who lived in Normandy and in the local communities, as well as those who once worked at the hospital, who could provide insight by sharing their personal experiences. One qualitative research method that lends itself to this inquiry is oral history.

Oral history is a method of conducting historical research through recorded interviews between a narrator with personal experience of historically significant events and a well-informed interviewer, with the goal of adding to the historical record. Because it is a primary source, oral history is not intended to present a final, verified, or "objective" narrative of events or a comprehensive history of a place... It is a spoken account, reflects personal opinion offered by the narrator, and as such it is subjective. Oral histories may be used together with other primary sources as well as secondary sources to gain understanding and insight into history. (University of California, Santa Cruz, n.d., About Oral History section)

Oral history includes a personal narrative that is acquired through interview processes. Multiple narratives can be analyzed and compared to find commonalities to better

understand a particular phenomenon. The “personal narratives help explain historical processes or events from the perspectives of people defined through a particular relationship to that event” (Maynes et al., 2008, p.130).

Further, oral histories provide different insight than official records that might be found in documents like meeting minutes, reports, or news stories. These are prevailing ways to understand the past and are often presented by those in power positions. However, oral histories have the “potential for restoring to the record the voices of the historiographically—if not the historically—silent...By recording the firsthand accounts of an enormous variety of narrators, oral history has, over the past half-century, helped democratize the historical record” (Shopes, 2002, p. 2). “Oral history is not only a tool or method for recovering history; it also is a theory of history which maintains that the common folk and the dispossessed have a history and that this history must be written” (Okiihiro, 1981, p. 42). Oral history does not negate the dominant history but instead provides new considerations. It offers “testimonies of witness to historic events to gain insights that are not found elsewhere” (Addis & Schlimme, 2016, Editorial section, p. i).

Oral histories can provide more than just facts of what happened at a particular time, they can provide context and meaning. They offer:

...an opportunity to explore what people *did*, what they *thought* at the time, what they *wanted* to do and what they *think* about it now. This approach acknowledges the dynamic nature of people’s memories and experiences as they weave together past and present. (Mallinson et al., 2003, p. 775)

There are challenges inherent in the oral history methodology because they record information at a particular time and are conducted with people and are based on their memories. They are not unbiased or perfectly objective.

All interviews are shaped by the context within which they have conducted [the purpose of the interview, the extent to which both interviewer and interviewee have prepared for it, their states of mind and physical condition, etc.] as well as the particular interpersonal dynamic between narrator and interviewer. (Shopes, 2002, p. 2)

Therefore, oral historians must develop and follow clear protocols when conducting interviews, thinking about the questions being asked, thinking about who is interviewing, and thinking about who is being interviewed (Lang & Mercier, 1984). The location of the interview and how that might affect an interview must also be considered (Okihiro, 1981). Interviewers should also be well-prepared to listen intently and “be prepared to accept a variant or a new version of a well-known event,” and “must guard against introducing their own prejudices and slighting the interview toward preconceived responses” (Lang & Mercier, 1984, pp. 85-86).

Another challenge of using personal narratives is that no set of oral histories that are connected to a particular scenario can tell the whole story. Because they are not exhaustive including anyone and everyone who experienced something, in this instance the closure of the Normandy Hospital, a *complete story* cannot be told. However, a collection of personal narratives might bring to light distinctive features or experiences that are shared by many, but not recognized as central in an individual’s story (Maynes et al., 2008). As Okihiro noted:

While oral history does not maintain that each individual's view of history is equally legitimate or that every voice must be heard, it does argue that by going directly to the people for historical documents, a more valid variety of history can be written. (Okhiro, 1981, pp. 45-46)

Even with the challenges inherent in oral history, Lang and Mercier assert that "Good oral history is reliable history" (Lang & Mercier, 1984, p. 99). Considering all these concepts, oral history is an appropriate research methodology for better understanding how the closure of Normandy Hospital has affected the health of Black residents in the community closest to the site.

Background for Conducting the Oral History Interviews

Semi-structured oral history research interviews are one of the most appropriate approaches to conduct an oral history. The researchers in this group were already acquainted with a few people whom we believed important to interview and that we thought could provide names of additional interviewees. We determined that a semi-structured interview process would be best as we wanted to establish positive connections with the interviewees because it is necessary "to build trust with the people you are trying to interview" (Ortiz, 2014, p. 2). "An honest and open interviewer-narrator relationship is the foundation of productive and reliable interviews" (Lang & Mercier, 1984, p. 99).

The research team decided that a script to begin an interview session would be helpful to make sure the interviewer covered all the information about the purpose of the interview, as well as to review the informed consent documents with the interviewee. We wanted to make sure the interviewees understood that not only the information that they shared, but their names and recordings would also be posted for public consumption.

“Because of the importance of context and identity in shaping the content of an oral history narrative, it is the practice in an oral history for narrators to be identified by name. There may be some exceptional circumstances when anonymity is appropriate, and this should be negotiated in advance with the narrator as part of the informed consent process” (Oral History Association, 2009, Principles, and Best Practices section). We also knew that if the person did not want to give consent, then the researchers would thank the person and then not conduct the interview. However, once the consent form was signed, the interview and recording could commence. The researchers also understood that at the beginning of an interview, the interviewer would want to establish a rapport with the person. Light conversational introductory questions would be the appropriate approach (Jacob & Furgerson, 2012).

Though the approach to oral history is a conversational tone, during the interview we knew that the focus should remain on the topic. A topic focus can help keep the interviewee as the person who is talking, instead of asking the interviewer questions. There is limited time for the interview, so it should be used wisely (Turner, 2010). Research on conducting oral histories also noted that an hour to 90 minutes is enough time to ask 6 to 10 good questions, and going longer than that is problematic. People may not be willing to devote more time, may tire during a long interview, or may get bored or distracted (Jacob & Furgerson, 2012).

The team also talked about the importance of listening without interrupting or giving feedback that might unintentionally influence the interviewer’s comments. “Listening is the most important skill in interviewing” (Seidman, 2006, p. 78). Active listening is necessary while making sure not to interrupt, or provide reinforcement like

head nodding, or saying “yes.” Instead, researchers should listen with interest and wait for the interviewee to finish speaking before asking a clarifying question, probing for more on that topic, or moving to the next question. Seidman (2006) notes that it is important to ask for more information if the interviewer thinks that there are more details that the interviewee can provide that would be helpful to the exploration. Seidman (2006) also talks about tolerating silence in the interview session. Sometimes people need to take time to pull their thoughts together or reflect.

In the oral history interview workshop that Paul Ortiz conducts, he talks about how to handle some of the challenges of learning sensitive information. This reminded the interviewers to let participants know that what they shared would be kept confidential if they requested it. If they would ask for the recording to stop, then the recording should stop. He further states:

If the person relates information that could potentially harm their job or immigration status, it is your duty to warn them that in oral history, there is no such thing as ‘lawyer-client privilege’ and that interviews can be subpoenaed by courts. It is appropriate to erase parts of a recording that contains sensitive information before turning it over to a library or archive. (Ortiz, 2014, p. 6)

We researchers agreed to follow these recommendations and protocols listed here and also agreed that when the interview was finished, we should thank the respondents for taking the time to talk and for sharing their personal stories. We agreed that we might also mention the possibility of a second, shorter interview, in case we had follow up questions after conducting interviews with other people. However, after the interviews were complete, we did not see a need for second interviews.

Participant Sampling

Since interviews are the primary method for conducting oral history research, we, the researchers of this study, decided to use this methodology for our data collection. We selected purposive sampling to identify participants, intentionally selecting people connected to the area of focus of the research who could bring rich information. Further, we planned to rely on snowball sampling for additional interviewees. Snowball sampling is “a form of purposeful sampling that typically proceeds after a study begins and occurs when the researcher asks participants to recommend other individuals to be sampled” (Creswell, 2015, p. 208). However, as we will relate later in this section, snowball sampling did not occur.

Because we researchers ourselves work in the St. Louis region and know people who were active as government and business leaders in and near Normandy as well as those who worked at the Normandy Hospital when it was open, when it closed in 2000 and when the site was sold in 2001, we each identified individuals for initial interviews. The original plan was to ask participants to provide a referral for others whom they thought would be good additional interviewees. Demographically, we decided to select the participants from the City of Normandy and immediate vicinity in the 63121-zip code including people who lived or worked there when Normandy Hospital was open and after it closed. This zip code geography is inclusive of several municipalities including Bel-Nor, Bel-Ridge, Bellerive Acres, Beverly Hills, Cool Valley, Glen Echo Park, Greendale, Hillsdale, Norwood Court, Northwoods, Pasadena Hills, Pasadena Park, Pinelawn, Uplands Park, Velda City, and Velda Village Hills. Residents in this geography are currently over 82 % Black (United States Zip Codes, 63121).

We planned to group interviewees into a few different categories based on their affiliations with Normandy Hospital including:

- Key community leaders and elected officials
- Hospital personnel
- University personnel
- General residents in the community
- Clergy
- Real estate agents
- Small business owners/bank staff

As noted, using a snowballing approach, the goal was to get recommendations from interviewees for additional interviewees. To start, we put together a list of potential participants in an effort to conduct about a dozen or more interviews. Then we planned to analyze these interviews to see if we were getting new information or if we were hearing similar stories. That would help us determine whether we needed to conduct more interviews to gather a fuller understanding of how the hospital closure affected health and wellbeing in the community. We intended and hoped for the collection of case studies to be exemplary, representing a broad range of ideas from a variety of differing perspectives.

Data Collection

After deciding how to conduct the research and putting together a list of potential initial interviewees, but prior to actually conducting the research, we applied to the University of Missouri-St. Louis Institutional Review Board (IRB). Part of the application submission included a consent form for interviewees (see Appendix A),

proposed interview questions, as well as the text for an email to recruit participants (see Appendix B).

On January 28, 2022, the research team received notification of IRB approval (see Appendix C) in the Exempt Categories (Revised Common Rule) 45 CFR 46.104d(2)(ii); Risk Level-Minimal Risk; and the approved documents included our Consent form, questions for the interviews, and the proposed interviewee recruitment email. At that point, the team finalized the initial interviewee list and started to reach out to potential participants to schedule interviews.

When initially reaching out to people, our team understood that it was important to give an overview of why we, the researchers, wanted to talk to them as well as a general sense of what types of questions they would be asked. Therefore, information explaining that session would be recorded and what would be done with the data that was shared was provided to the participants prior to the interview.

Setting up the actual interview is an important step in the whole process. It was important to accommodate the interviewees as much as possible. This included finding a time when they would be available and most comfortable having a conversation. Because the research team also wanted to assure having both a Black and White researcher participating in the interview, scheduling was more of a challenge than we had anticipated. We conducted outreach by email and telephone calls to potential interviewees. February 23, 2022 was the scheduled date for the first interview. Once the date and time was confirmed for each interview, a Zoom link was set up and sent to the interviewee along with a copy of the consent form as well as the list of questions that would guide the interview. Subsequent interview scheduling followed the same protocol.

All of the participants had a connection to the Normandy Osteopathic Hospital and the surrounding community during the timeframe of its closure. Not only did we identify categories of connection (e.g., doctor at the hospital), but we also decided to gather general information about the participants including gender and race to see if there are commonalities or differences of experience among these groups.

Interview Protocol

The plan for the semi-structured interviews was for them to take approximately one hour in length. Keeping to a time frame for the interview was discussed and agreed upon with the interviewee. This was an important focus because “Extending the interview causes an unraveling of the interviewer’s purpose and of the participant’s confidence that the interviewer will do what he or she promised” (Seidman, 2006, p. 21).

All of the interviews were conducted through the Zoom software platform, and each participant answered the same series of questions for consistency. Nine were face-to-face where the interviewers and the interviewees could see one another. One interview included only the audio conversation.

A team of at least two of the researchers conducted each interview and sometimes three or all four researchers were present for the interview. Each interview included at least one Black researcher and at least one White researcher. We reasoned that having multi-racial representation in the interview might help the interviewees be more at ease and open with their response. We thought that might not be the case if, for instance, only White researchers were interviewing an African American person, or vice-versa. In the cases where more than two researchers were present for the interview, only two of us asked the predetermined questions. Any of the researchers present then asked probing

questions for follow-up as needed. The purpose of this distinction was an attempt to ensure comfortability for participants to authentically share their experience as relates to the hospital and impact on the community. The interviews were recorded and then transcribed.

As noted, we asked participants a set of guiding questions then asked follow-up questions for additional information and clarification. Yin asserts that, “challenges of the interview process include bias due to poorly articulated questions, response bias, inaccuracies due to poor recall, and reflexivity” (Yin, 2018, p. 114). To address these concerns we created an interview protocol using a standardized list of questions. In Daniel Turner’s article on Qualitative Interview Design, he notes that “according to Gall, Gall, and Borg (2003), this reduces researcher biases within the study, particularly when the interviewing process involves many participants” (Turner, 2010, p. 756).

Therefore, our team developed not just a list of pre-set questions, but an interview guide to follow (see Appendix D). As noted, prior to each interview, the interviewers both shared some background of the research with each participant and sent a copy of the interview questions along with the consent form for signatures. At the beginning of each interview, referencing the interview guide, one of the team members read a brief overview of the study, asked if the interviewee had received and read through the consent form, then read through sections of the consent form. One of us who was serving as an interviewer then asked for verbal acknowledgement of the participant’s consent to take part in the study with an understanding that the recordings would be posted on a website. We then asked if the participant had any further questions before the recording started. Once the participant gave verbal understanding and consent, the recording started and the

research team proceeded to ask questions. The interview guide was a tool to help provide some consistency between the different interviews (Turner, 2010). Even so, the interviews were conducted conversationally with additional probing questions about perceptions and how participants felt about experiences, as is the format for oral history research. The guiding questions were:

- How were you affiliated with Normandy Hospital? (e.g., What was your first memory of the hospital or last time you were there?)
- What types of services and activities were offered at the hospital?
- How do you believe the hospital affected your health and wellbeing personally?
- How do you believe the hospital affected the health and wellbeing of the members of the community?
- Why do you believe the hospital closed?
- After the hospital closed, what do you think the effects were on the community?
- How did the closure affect access to healthcare for community members?
- What, if any, do you think was the economic impact of the hospital closure?
- Is there anything else that you would like to share that you think people should know about the hospital closure?

After these questions were asked, the team members thanked the interviewee and turned off the recording.

As part of the snowballing process, we then asked the interviewees if they could recommend anyone else who might be able to offer a different perspective or insight on the hospital closure and subsequent effects on the surrounding community.

Unfortunately, people who were mentioned are now deceased, so we felt very fortunate to be able to interview these ten people who are still actively involved in the community and able to share their stories. At the end of the session, participants were told that they would receive a link to the interview that they could review and would be given a chance to change their mind about having the interview posted publicly on a website.

After the interviews conducted on the Zoom platform were completed and the recordings were processed and made available through Zoom software, each recording was downloaded onto the university's secure Google Drive. Interviewees received a link to their interviews in a subsequent email message noting that they could change their mind about having the interview published, and that they would need to respond if they had changed their mind. In addition, a member of the research team followed up with interviewees who had not sent back a signed consent form, though every one of them did a verbal consent prior to their interviews. Further, they were told that the web address of the site where the oral history recording would be posted in the future would be sent to the interviewees once the web page was complete. The ten interviews were provided to the University of Missouri-St. Louis Digital Humanities and uploaded for future access to <http://umsldigitalhumanities.org/perspectives-the-impact-of-the-closure-of-normandy-osteopathic-hospital-on-the-surrounding-community/>. Interviewees were sent this link in a follow-up email message.

Analysis of data

All of the researchers either participated in the interviews or reviewed the recordings afterward, or both. After each of the interviews was finished, one of the researchers uploaded both the recording as well as the software auto-generated transcript into a Google folder for ease of access and editing online. The documents are located in a file that is only available to those who have specific permission to access.

We then split up the transcripts to clean them up making sure that the transcript actually matched the recorded conversation. For half of the interviews, the Zoom-generated transcript was then processed through Otter.ai software with the hope that it would provide a more accurate transcript of the interview. However, that was not the case, so we primarily relied on the Zoom auto-generated transcript for cleanup. We did not run the remaining transcripts through the Otter.ai software. Cleanup of the transcripts took many hours, but was important. Many words and particularly names of people and places were incorrect in the auto-generated transcript. For example, the word *Normandy* almost always showed up in the transcript as the word *normally*. Further, the auto-generated transcript left out a lot of punctuation. Therefore, cleaning up the transcripts was necessary in order for the written document to accurately reflect the words spoken in the interviews. “Transcription is crucial to your research project and, while time consuming, it is important that this task is completed thoroughly and to a high standard—errors can significantly change the meaning of your data” (Terry & Hayfield, pp. 22-23).

We originally had planned for at least two of the research team members to read through transcripts to code comments applicable to the research study. We were going to employ initial coding, also referred to as *open coding* (Saldaña, 2016) as the first cycle of

coding. Afterward, other members would review and ratify coding, then discuss and clarify operational definitions of each code. We were planning to divide transcripts between researchers for coding and then members would audit another's work. However, the research team learned about reflexive thematic analysis and chose this as our data analysis approach. The reason being was that reflexive thematic analysis is “designed to be a fully qualitative and interpretative way to do analysis” (Terry & Hayfield, p. 9).

Further, reflexive thematic analysis is:

...interested in resonance, transferability, and situating the research within a particular context. These researchers are not concerned with the truth, but rather producing knowledge which represents situated truths, where the research—informed by theory and an understanding of a research area and culture—can bring insight into that area. (Terry & Hayfield, p. 9)

The first step in the reflexive thematic analysis process is familiarization with the data. Therefore, as noted, each of the researchers reviewed the recordings. We also read and re-read the transcripts of each interview to more fully learn what each participant shared in their interviews, to understand their experiences with the Normandy Hospital and their perceptions of how the closure affected individuals and the community.

The research team uploaded the clean transcripts into Dedoose, a secure online tool for data management, excerpting, coding, and analysis. Each of the team members downloaded the Dedoose application on their computers so we could work collaboratively on the project. The team then embarked on the second step in reflexive thematic analysis—open ended coding—as we had originally planned. To start coding, words and phrases from the literature review related to the social determinants of health

started the code list as A Priori codes. One of the A Priori codes in the original list was *good quotes* since we knew that we wanted to use the actual words of interviewees to support their research. Another A Priori code was *oral history* because some of the stories in the interviewees, though not directly connected to the closure of the hospital and the aftereffects, were stories of personal experience that provide a different insight into an historical event. After determining the A Priori list, each of the researchers individually began to do initial In Vivo coding of each transcript.

After each of the researcher team members coded every transcript individually, we then downloaded the list of codes into an excel file. In total, there were more than 300 codes. The team reviewed the list and clustered the codes that were similar in content. Looking at these clusters or groups of codes, we considered how they are connected and which were related to our research question. Some clusters were just general comments that occurred in many of the interviews but did not connect to the research.

Theme generation was the next step in the process. The research team used a whiteboard to take clusters of codes and promoted some of these codes to become prototype themes. Together, we reviewed and discussed the themes at length talking about how the data gathered in the interviews spoke to the selected themes. We talked about what each theme meant and the codes and notes that should be included in the theme and which should be left out. We gave these final themes names. Then all notes and quotes were reviewed from a thematic perspective to better understand the information that was gained during the interviews.

Focusing on the themes, we created a report to discuss how the data that came out of the interviews addressed the research question. The Dedoose software also proved

useful in helping the research team understand if and how different interviewee groups provided similar information in their interviews based on their demographics. The list of demographics included gender, race, occupation, leadership role and affiliation with the university.

Summary and Ethical Considerations

The research protocol used for this study was appropriate for Oral History inquiry. Listening to personal experiences and finding meaning in these is the primary focus of the study. As with other characteristics of qualitative research, “The focus is on process, understanding, and meaning; the researcher is the primary instrument of the data collection and analysis; the process is inductive, and the product is richly descriptive” (Merriam, 2009, p. 14). The question of trustworthiness can be challenging in Oral History. According to Yin (2018), trustworthiness is supported by construct validity, internal and external validity, and reliability. For construct validity, the operational measures that the researchers took were appropriate. Internal validity is not necessary because the study is not seeking to explain, but to describe and explore. Similarly, for Yin external validity focuses on whether the research findings have generalizability. The exploratory nature of this study on people’s lived experience is not necessarily conducive to generalizability, but for understanding. Again, the method of reflexive thematic analysis is not conducted to find one truth, but instead it is for digging into the data and discovering and exploring situated truths for understanding. Reliability, however, is important in this study to support trustworthiness. We as researchers attempted to be very explicit in the protocols which we used including an interview guide, paying close attention to how we collected and maintained the data. The protocol may be able to be

replicated with an expectation of the same results in obtaining information and understanding of personal experiences.

Ethics and confidentiality are important components of qualitative research to protect participants and to support a trusting relationship between the researcher and participants. We explicitly addressed ethical considerations in our research process. We first gained the University of Missouri – St. Louis Institutional Review Board’s (IRB) approval to conduct the research. We used a consent form and made a point to explain it as well as the purpose of the study during each interview. We also used an interview protocol to assure alignment of each interaction. Though usually oral histories include the identification of the narrator (Oral History Association, 2009), if an interviewee had asked for anonymity, to maintain the confidentiality of the participant, we would have assigned the interviewee a code name or fictitious initials for use in description and reporting. However, none of the interviewees asked for anonymity. To protect the chain of evidence, the research team decided to use the university Google drive to make sure that all data, files, recordings, etc. are secured and only accessible to those who have permissions. As researchers, we understood that some of the information shared might be sensitive, though we did not inquire about specific medical experiences. We conducted our research in an ethical manner guided by the Belmont Report from the Department of Health, Education, and Welfare in 1978. “The three basic principles of this report involve the beneficence of treatment of participants (maximizing good outcomes and minimizing risks), respect for participants (protecting autonomy and ensuring well-informed, voluntary participation), and justice (a fair distribution of risks and benefits)” (Creswell, 2015, p. 22). With the permission of the interviewees, the oral histories have been given

to a repository, specifically the UMSL Digital Humanities program, for future research.

Any other files or data will be destroyed in a timely manner according to the rules and guidance of the University of Missouri.

Chapter 4: Findings

Introduction

The purpose of this co-authored, qualitative research study was to use oral histories to examine the relationship of the closure of the Normandy Osteopathic Hospital to social determinants of health—specifically access to care as well as to economic stability in income and wealth generation—for the Black community in and around Normandy, Missouri, a near-North suburb of St. Louis. In the end, our research team interviewed ten people for this study through purposive sampling. Though the team did not set a specific target on the demographics of the interviewees, we believe that we achieved good diversity in participation. Half of the interviewees were women and half men; half were Black, and half were White. The interviewees were either current residents in the Normandy vicinity or had lived there previously when the hospital was open. Though the research team did not specifically ask interviewees about their ages, they analyzed that all are between the ages of 60 and 85 based on either personal knowledge of the interviewee and/or timeline of experience at Normandy Hospital.

As for affiliation with the hospital, three of the interviewees had been doctors at the Normandy Osteopathic Hospital and had medical offices nearby. Of the doctors, one was a Black female, and two were White males (and all three are still practicing). Three interviewees were community leaders, with two having served as elected officials for the vicinity and one serving as a pastor at a local church. One was a Black female, the other two Black men. The remaining four participants worked in the community in different businesses. Of these, one was a University of Missouri-St. Louis employee who has been at the university since 1983, working in public affairs and economic development.

Another worked at a local bank from 1974 until retiring. The third runs a small business that has been owned and operated by her family in Normandy for fifty years. The fourth is a real estate agent specializing in residential and commercial sales and construction. In the group of businesspeople, one was a Black woman, two were White women, and one was a White man.

Several different social determinants affect health outcomes. The focus of this research team and the overarching themes that directly relate to social determinants of health discussed in earlier chapters include 1) Access to Health Systems and Services and 2) Economic stability through income and wealth. Subthemes for Access to Health Systems and Services surfaced in the research like two sides of a coin. The different perspectives were contrasting. One side shows the benefit of having the hospital and associated health services in the community. The other side shows disadvantages resulting from a lack of the hospital and health care available in the community.

Two different but connected perspectives surfaced in the data collection as it relates to Economic stability through income and wealth. One was economic wealth as personal and generational and includes the capacity to build wealth through means like employment opportunities. The other side is community wealth which is strongly connected to the community environment and community pride as well as economic investment in and for the community (including built environment).

Woven throughout the data was another theme that we have labeled Systemic Factors. These were more subtle topics that came up in the interviews that participants believe may have influenced the hospital closure. For instance, by the late 1990s, doctors of osteopathy were being allowed to practice in hospitals affiliated with the American

Medical Association (allopathic hospitals), whereas they had only been able to practice in Osteopathic hospitals in earlier days. In addition, other hospitals in the St. Louis area were moving westward at the time building new facilities outside the city limits and connected communities.

Access to Health Systems and Services

Normandy Osteopathic Hospital was a community hospital. The community grew up around the hospital, and the neighborhood and surrounding businesses had a symbiotic relationship with the hospital. Participant Dr. Michael Spezia remarked, “This little hospital grew up in this area from a little 50 bed, one wing institution to about 190 beds, at its peak, and wonderful memories, good care for those involved, and it impacts us all.”

Availability- “Having a hospital close by was invaluable to the community”

According to the data, Normandy Osteopathic Hospital was critical in the community for many reasons, with access and availability of services both at the hospital and in the surrounding community rising to the top. “Having a hospital close by was invaluable to the community,” noted participant Sheila Forrest.

The hospital was well-used by the community. All of the interviewees either had used services at the hospital themselves or knew someone who did. According to the data gathered during the interviews, it was a full-service hospital with an emergency room, inpatient care, obstetrics, and delivery rooms. They offered needed services as a community hospital, and they had the staffing capacity to deliver them. Dr. Spezia recalled:

We got a house staff of 75 doctors. We had 25 externs—that’s the level of care you get before an intern. We had 25 interns. Then we had 25 residents going to

house staff of 75 doctors that were treating that community hospital in all phases. We had obstetrics, pediatrics, internal medicine, and geriatrics. We get all of the pulmonary, cardiac, GI, and every specialty you can imagine. EMTs were all there at that hospital. And each service had a resident, an intern, and probably an extra in training with the attending physician, so the hospital was a full-service hospital. Now we didn't do open-heart surgeries at that time because that was a very sub-specialty issue, and very few community hospitals were doing that. That was your tertiary care centers. But as far as diagnostics therapy, a pharmacy, all the basic medical treatments, they were there in conference within the Normandy hospital.

Participant Dr. Peggy Boyd Taylor recalled that the hospital had an admission rate of 1,000 patients. (This was something that she shared in her interview with the external business in the late 1990s when they were deciding whether reopening the hospital was viable. That company eventually bought the hospital and reopened it for a short time.)

The closeness or proximity of the hospital to the people in the community made a difference in health outcomes. Transportation, including issues with travel for those who do not have healthcare services nearby, is one of the social determinants of health. However, distance to care was not a problem in Normandy. "I mean, you could literally walk to the hospital if you needed to because it kind of serviced this whole Normandy area," Ms. Forrest shared. "This, the idea of living five minutes from a hospital, is an added resource—just five minutes from the house, and she's there," stated participant Charlie Dooley. Another participant, Pastor B. T. Rice, also noted how accessible the hospital location was with both highways 170 and 70 not far away from Normandy. He

said, "What is it when you can get straight off at Hanley Road—those were close accesses and ways they could reach Normandy hospital."

Further, people who came to the hospital could also expect it to be open and fully functioning due to its location in the community. Rita Days noted:

A lot of folks in the neighborhood worked at the hospital. You had your, you had, of course, your doctors, but you also had nurses, you had people who ran the gift shop, you had people who were janitors and nurse assistants and, and all those kinds of folks generally live in the area. So you know, when you had bad weather, if you will, they could still make it there because it was not that far for them to go.

Additionally, people may have come to the hospital for a specific treatment, but then found themselves a *medical home* for regular, preventative care. Rita Days commented:

And even with, even with just minor issues, if you did not have a health care home, you could go there. We know the days of when you wanted to have something done before the emergency rooms got so expensive. Most people would go there, maybe go there and get their medications, and get there, see the doctor...they tried to make sure that everyone who needed a health care home had a health care home. And, of course, the hospital was an extension of that.

Dr. Spezia also commented on helping patients find a medical home. He said:

I saw many patients who eventually became my patients in my private practice at that time because they had no doctors. So, we found the big need in the community, and we've lived through this need with patients who are not assisted or associated with a family practitioner or medical liaison. So, they were constantly going from E.R. to E.R., clinic to clinic, and bouncing back and forth

with no affiliation. This way, if we saw the patients and brought them into the practice, they had a medical home. Before this, before that term [medical home] became popular, we were the medical home. And if they needed specialty help, they were given a referral. If they needed an emergency treatment, same thing would happen. And if they required admission to the hospital, we would admit them to the hospital in their neighborhood—the Normandy Osteopathic Hospital. So, that was kind of the whole, kind of rotatory type of movement of the patients. Took them from an area of no medical care whatsoever, to fragmented care, to concentrated care within the family medicine auspices. And then we got them into their specialty clinics, hopefully, to avoid their tertiary disease states of uncontrolled diabetes, uncontrolled hypertension, chronic kidney disease, end-stage renal disease, dialysis, tumors that weren't being treated—the whole gamut of medicine that we were seeing that were not treated early or not treated at all.

After interviewees talked about how the presence of the hospital affected the community, they shared their thoughts on the impact of the hospital closure. From this, the researchers heard a myriad of ways that the closure impacted access to health care. As the hospital closed, there were few options for health care within the same geographic footprint. Transportation to care was a significant theme. Interviewees went in-depth to describe this shift. Pastor B.T. Rice asserted:

It's fine to have a big beautiful medical center somewhere, but if you don't have access to it, then it really is not very helpful. So, by closing Normandy hospital for those that did not have transportation and then they didn't have the bus line that would go to those various hospitals...access was crucial.

Similarly, Mr. Dooley reflected:

You say 50% of the appointments are missed, not because they didn't want to, but didn't have transportation. The car broke down that day, they didn't have a way to get there, or they can't take off from the job...It was always something so, can you imagine what it is, if it's far away, that people talk about access, that's what access means.

Or, as Dr. Knapp put it:

[It] really voided the areas of health care. Which, in that case, is hard enough because it's going to make the population in the area sicker. You know, they're not, they're not going to go with, they're not going to get as much done if it's, if it's a hardship to get there.

Community leader Rita Days summed it up:

I think health outcomes were affected because people did not have transportation to get further out; they did not necessarily have the clinic structure here to make sure that folks could get to a clinic and get their health care needs...so people were left without, and they would visit when they had an issue. So it would not, it would not be preventative kinds of health care where the people could avail themselves to. That just wasn't, wasn't here.

Normandy Hospital was not a luxury, but a necessity in the community, especially for those who lacked transportation. After the hospital's closure, "People had to go to Barnes or out to Christian Northeast, which are both long distances away. And if you're reliant on public transportation, you know multiple transfers from buses and, you

know, to get to it, and so the community really suffered from a lack of access to... healthcare," noted Dr. Knapp.

People in the community understood the need for access to care, but it was also confirmed when the community received a Certificate of Need to support keeping a hospital open. Along with others advocating for the hospital, Rita Days talked about the process for getting this designation from the state.

We worked with them very hard; it was almost a year process in order to get a certificate of need.... And certificates of need, by the way, are very, very competitive. Everybody doesn't get them because you asked for that. And so putting together a package of needs and how are you going to sustain the facility, all that had to be done. And we did that, put that together, and were awarded the certificate of need.

The evidence they prepared showed that the community needed to have healthcare available in the community.

Access to healthcare, however, is more than just proximity to services. The capacity to avail oneself of these services is also crucial to access. This includes the ability to pay for services. Dr. Taylor specifically spoke to the affordability of care as one reason that the hospital was critical in Normandy, saying:

And so, the community depended upon the hospital to be open because it was community-based, the fees were lower....I don't know how big the community was, but the community chose doctors for primary care, OB, and orthopedic surgery. They all chose doctors that were there at Normandy Hospital because it was in their community, it was [easy] to get to, and the fees were low.

This was at a time before insurance companies had dominated the healthcare industry. Dr. Taylor noted that office visits were only \$10, saying, "I'm 83 years young, and nobody had health insurance. And then a company called Sanus (s-a-n-u-s) came to town, and they were the first ones to offer patients insurance that covers the office." Participant Terry Gannon also commented about insurance, stating, "My parents didn't have insurance. You just paid the doctor, and it wasn't that expensive because, you know, we just paid."

The data suggest that funding for healthcare services changed dramatically during the time immediately prior to the closing of Normandy Hospital, and this connected specifically to the rise of the healthcare insurance industry. Insurance began to dictate what services doctors could provide based on new guidelines. Dr. Taylor recalled:

And they sent me a letter and said, "You can't do this, you can't do that, you can't, you can't, you can't, you can't." And I thought, "What do they think they're talking to? I've been doing this stuff for years." And I soon found out that if I didn't follow the guidelines they said, "We'll just kick you out."

Additionally, as more people got insurance and insurance companies began to negotiate contracts with hospitals, some institutions like Normandy Hospital were left out. Dr. Spezia mentioned this in his interview saying:

But there were some of the, oh here we go, the HMO or PPO from coming on board. So we found out that some of these HMOs, they would of course affiliate hospitals, you know, for their members to go to. Blue Cross/Blue Shield, Aetna, Cigna. Well, come to find out that many of them were not putting Normandy Hospital on their panel. So we, of course, inquired about that. We said, "Why

not?" And there was a lot of bantering around, and we found out that, well, they just didn't want to keep another hospital in that, in that network. And I can't say this for sure, but there may have been some influence from other systems that said, "If you want us to stay in, you need to decrease the amount of competition."

Again, Dr. Taylor remarked that people in the community "had health insurance and they could not use Normandy the hospital." Their access to close, reliable service had gone away. The cost was another compounding factor, as she stated, "And when they closed the hospital, they had to go to a large trauma center where it would cost them triple the amount that the small community-based hospital, Normandy Hospital, cost for the families."

Trust- "Everybody knew where it was, how to access it, and somebody who worked there"

Capacity to use services also encompasses comfort level and trust in the health system. As noted in a previous chapter, there has been a long-standing distrust of medical care in the African American community due to a history of poor care and mistreatment. Even so, the data suggest that Normandy Osteopathic was a trusted entity as a community hospital. Rita Days noted:

It was a community facility. And everybody knew where it was; everybody knew how to access it. Everybody knew somebody who worked there. So, it was, it was just, it was devastating to the community when it closed; but everyone in the community was very supportive of that facility.

Dr. Spezia called Normandy Osteopathic a *premiere hospital* that did not just offer medical service to patients. It was a training hospital where both Black and White

doctors practiced and learned together. Participant Betty Van Uum also used the word *premiere* in her recollections. She said, “Normandy was really the national Center and the Normandy Osteopathic Hospital was the national Center for osteopathic training for osteopaths from all over the country. It was their premier facility.”

The hospital was also a meeting place in the community where people felt belonging. “Police had breakfast at the hospital every morning,” recalled participant Dr. Stephen Knapp. Retired doctors who lived in the neighborhood would regularly stop at the hospital. “It was a meeting place. It was a place where there was camaraderie. In the doctors' lounge, when we got in the lounge they'd have our breakfast. A doctor would talk about an interesting case,” Dr. Spezia fondly remarked:

The word *family* was a common term in the data, especially in interviews with the doctors who worked at Normandy Hospital. Dr. Taylor said, “It was like a family. It was a small hospital; we were considered as a family—everybody knew each other, and it was a wonderful place to work.” For participant Joseph Riebold, he had a family connection, too, as his father was one of the seven people that founded the hospital. But, more importantly for the community, Dr. Knapp stated that “it was a family, and it projected a family feeling that made the patients feel good.” Dr. Spezia spoke about their trust with their patients who had a medical home with them “because they are attached to you, and they know that you're there for them.”

It was not just about care *in* the hospital either. Terry Gannon talked about how the doctors know you and your family. She exclaimed, “If something was wrong, well, your mom just called the doctor, and then they would just send out a prescription, or you

would just run up there. And he'd go, 'You got the chickenpox or whatever.' I mean, we don't have that anymore." The care was close, trusted, and it was accessible.

Additionally, having the doctors, nurses and other medical professionals living and working in the community helped people see and understand healthcare on a deeper level. As Betty Van Uum attempted to explain when comparing what she call the current situation in Normandy:

It's not exactly the same kind of level of service that you get if you have a functioning hospital in the middle, with, supported by practitioners, who live and work in the neighborhood and a general understanding of medical care that is needed, that you communicate to your children and their children communicate to your children and everybody has a general sense of how and where to get things done.

Affiliated Services- "There were Mom and Pop pharmacies...and doctors nearby"

"We had a lot of medical services and medical people living in the neighborhood because of the presence of the hospital," recalled Ms. Van Uum. There were, as Terry Gannon fondly called them, the "mom and pop pharmacies, the little drug stores" where people could get their medicine and other supplies. The doctors also had offices in nearby buildings. Before becoming a doctor herself, Dr. Taylor lived in the community and worked in the hospital. She shared her experience:

So, I used Dr David Gardner, even though he was a cardiologist, I used him as my primary care doctor. And doctor Muriel Gardner was his wife, and she was the primary care doctor. So when I needed something, I would go right down the street, to the right, they were just about a block down, and I had an appointment

and I got to see Dr. David or Dr. Muriel Gardner...And now I'm pretty healthy and I occasionally may have a backache or allergies. Back then you didn't buy allergy medicine over the counter. And then they'd give me a prescription, and then I could get it filled, and go home to my family.

Terry Gannon also mentioned the accessibility of doctors being readily available nearby. "A pediatrician that lived up at the Wedge...and everybody used Dr Mary, and you just took your kids up there." Betty Van Uum reiterated this type of experience stating:

When I was a child, if you were a kid and you cut your finger, Dr. Josephs could tape it up or Dr. Shaner could stitch it. Or, I mean, there were people there. Or Mrs. Lassido was the nurse, and she said, "Oh, you need to go see your..." That, I mean, those people were no longer in the community, right.

Critical Care- "If you've got a heart attack, if you've got a stroke, time is brain, time is heart"

Having a hospital close by is important for more than just regular health checks and illnesses. It can make a difference for someone in need of emergency care. Pastor Rice stated:

It could have been a matter of life or death because to remove Normandy hospital put other medical centers further and further away from the community. So, if you have a hospital that offered services that one would need just for survival, then certainly to remove the hospital from the community really could be a matter of living or dying.

Business owner Sheila Forrest mentioned customers who may have needed, in her words:

...immediate attention. I mean we've had situations where somebody passed out in the store or you know or a car accident in, you know, in the parking lot; or a car accident on the street that's in front of us. You know you've had major things of that or something happens at the bus station. But, when you see those things happening, it's a matter of how fast they can get care.

She also spoke to life and death emergencies like a heart attack or stroke where time is of the essence in getting care and that “it was good, good, good having Normandy here...”

However, it is not only about life and death situations. The hospital was there for other emergencies. Dr. Taylor mentioned that the hospital was close to the airport. She recalled, “And whenever somebody gets sick at the airport, the ambulance brought them where? Normandy Osteopathic Hospital.” Rita Days remembered when her godson was at her house and broke his arm while playing in her basement. She was happy that the hospital was “maybe 100 feet from my doorstep. And so you could get there in under five minutes.” That is a huge relief when you have someone in pain and needs immediate care.

As important, the people who went to Normandy Hospital got personal care. Even after the hospital stopped delivering babies, community members would show up. Dr. Spezia recalled:

When they built the West hospital they changed the OB to that area, but still patients would show up in the E.R. at Normandy hospital. In one case, I had to ride in the ambulance with the patient and deliver the patient on Manchester road, before we got to the hospital.

Dr. Spezia noted that after the hospital closed, “The patient population...had difficulty getting to an institution without having more side effects that can occur, so time was the issue.” Dr. Knapp noted how distance could also impact loved ones' experiences, which is not always considered when discussing access to care. He noted, “We all would like to get health care close to home, you know, so that you're not going long distances for things. And then, your family can't come and visit.” Another interviewee, when asked about how the closure of the hospital affected the community, also reflected on the critical aspect of time, especially when other providers were overwhelmed with patients.

Well, it was immediate. We had patients that had, they didn't have the access to care, so they went to Christian Northwest at that time, or to DePaul. And I can tell you that at Northwest the waiting room in the E.R. was so busy, they had to bring double wide trailers in the parking lot to put the patients waiting for medical care. That's how bad it was. And the same thing with DePaul. They were overrun. They couldn't see the patients in a timely fashion. So, it was immediately felt by the community and there were some very, very tough conditions where the patients now who are maybe 2, 3, 4 or five minutes away were now 25 to 30 minutes away from another institution. And if you've got a heart attack, if you've got a stroke, time is brain, time is heart. And the more time in between, the worse the prognosis.

Normandy Osteopathic Hospital and the connected health care services made a difference for the community. All of the participants provided data to support this assertion multiple times throughout their interviews. In reference to the hospital, Charlie Dooley said, “the closer it is with the community, the better the health care that family

will receive. It makes a big difference in the health and mortality rate of the community.

It just makes a difference!” Dr. Spezia aptly stated:

It was a major impact in their health and wellbeing. It was an area where they could get their health care. It was an area where they could avoid tertiary disease states, where we could impact their health, both physically and socially.

Dr. Taylor declared, “So it was an important part of the community, and if it was open today I’d still be sending patients here.”

Systemic Factors

In addition to documenting changes in access to care and health services, interviewees provided historical context on the significant systemic factors that influenced the closure of the hospital.

Bias and Changing Trends- “They had actually voted to move”

While a void in health care after the hospital closure is reflected specifically through the stories of the Normandy community, interviewees spoke to larger trends regarding the loss of accessible health care. This was an unexpected area of discussion that the research team found both surprising and interesting. Betty Van Umm spoke about the changing acceptance of Doctors of Osteopathy in the predominant medical field (affiliated with the American Medical Association), and that recruitment of these doctors by allopathic hospitals (again, the predominant or traditional approach to medicine affiliated with the American Medical Association) increased as bias against them waned. This opened opportunities for these doctors to affiliate at many more institutions, not just osteopathic hospitals. Pastor B.T. Rice spoke about the larger movement of hospitals that were relocating away from the city and away from serving Black communities within the

St. Louis footprint. Normandy Osteopathic opened a new hospital in the southwest part of St. Louis County. Pastor Rice noted, “DePaul hospital had planned to move southwest or more West and more South out in the 40 and 270 area. They had actually voted to move.”

These stories may reflect a larger trend of reduced medical care access that Black communities were experiencing then, and which carry forward into current experience as well. Pastor Rice also spoke to the coalition that was formed in order to maintain access to health care for the Black community, through the alliance of the Urban League and Black faith leaders who spoke out against the departure of health institutions.

Additionally, some longstanding hospital leaders and stakeholders worked to retain the hospital’s presence in the community. These efforts drew on the voice of the community and community leadership in order to determine what direction would best serve the residents of Normandy and the surrounding neighborhoods. How the community members marched to increase support for keeping a hospital in the community is a story that surfaced in the interviews and was not something that the interview team found in earlier research materials.

Systemic Racism- “All I know is that in our [Black] communities, there seems to be less investment or concern about their health”

Given the demographic shift in the Normandy community from majority White to majority Black in the last quarter of the 20th century, the individuals who benefited from the longstanding medical care offered by Normandy Osteopathic Hospital, in the end, were mostly not of the same demographics as those who were impacted by its loss.

Interviewees noted that Black residents were disproportionately impacted, compounding

health inequities that were already present due to systemic racism and disinvestment. As Rita Days said:

African Americans do not have the appropriate health outcomes, number one, and so they don't have the necessary preventive kinds of health initiatives that they should have in order to stay healthy. And so, I think that has been one of the tragedies of having that facility close as well. And, and so, you leave a lot of African American people living in this community and the surrounding communities without care. I think the closest facility may be DePaul. And that's way out on St. Charles Rock Road. And so, but again, you're leaving a group of people who really have a lot of comorbidity issues from the beginning, and you're leaving them with very little options for health care.

Similarly, Charlie Dooley noted, “In minority communities, the ones that need the most have less access to health care.” Pastor Rice stated, “You could go on and on, as these communities began to change racially, it had an impact on how much the powers that be would invest in Normandy Hospital. Race was indeed a major factor, I believe.”

Likewise, Charlie Dooley expressed:

When a community begins to change its complexion...become rather than a majority majority, it becomes a majority minority, it seemed like the interest is not there, the investment is not there...All I know is that in our [Black] communities, there seems to be less investment or concern about their health.

Race as a factor pertained both to the closing of the hospital as well as the inadequacy of medical care that has become commonplace in the 21st century—namely free-standing urgent care centers. Mr. Dooley continued, “The African American community has not

fully bought into the urgent care centers...when there's an accident or situation in their home... their mind's still on the emergency room.”

Interviewees noted the inequities that were apparent in the loss of the hospital, an example of how the closure was reflective of a larger pattern of inequities for Black communities. As Charlie Dooley stated, “Why is it in minority communities, we have to leave our community to get healthcare? I needed something. It's not a...how do you say it...an extra. It's a necessity—you have to have it.”

While not the specific focus of this study, it should be noted that interviewees shed light on the reasons behind the closure of the hospital, reflecting the pervasiveness of disinvestment that was occurring in the Normandy community at the time, particularly as it coincided with a change in the racial demographics of the community. Dr. Spezia noted that hospital administrators attempted to claim reimbursements from private insurance and yet were denied claims, with the suspicion that they were being cut out because of favoritism toward other providers, potentially in wealthier communities. Medicaid claims for patients who relied on a low income were utilized in 20% of the cases at the Normandy Hospital in 2000, yet it should be noted that these claims were not sufficient to pay for the care that patients were receiving (Manning, 2000), pointing to structural disinvestment in low-income communities on the federal and state level. Beyond that, the mismanagement led by a Texas health care company that managed the Normandy hospital for five years deserves its own inquiry; however, interviewees noted that the company exploited the hospital in order to regain its license in Texas, and amassed unpaid debts to St. Louis affiliates to the total of \$2 million (Manning, 2000). The company's blatant willingness to disregard local businesses and hospital doctors

(who financially contributed their savings in the goal of keeping the doors open) could yet be seen as another example of disinvestment and exploitation of a Black community desperate to keep health care access a reality in their community. Finally, several years after the closing of the hospital, UMSL staff member Betty Van Uum noted that the University of Missouri System made a more recent policy decision—namely benefit selections that excluded a potential local provider interested in serving the neighborhood—that has subsequently hindered the ability of UMSL to fill the gap in healthcare in the Normandy footprint. This decision in 2016 was cited by Ms. Van Umm as “just another example of disinvestment in what is now a majority Black community.” She went on to say, “It was a terrible decision that mirrored the absolute disinvestment that we have seen from governments and from private industry...in the Black community.”

These reflections on the circumstances of the closure of the hospital add up to layers of disinvestment over time—from the low rate of reimbursement of Medicaid at the federal level, to the exploitation by a Texas company that left the hospital in major debt, to the UM System benefits decisions in 2016 that alienated a local medical partner. Interviewees shared stories of how they individually and collectively attempted to overcome these barriers—from the coalition of Black leaders fighting for medical care in the Black community, to the band of doctors who put their life savings into keeping the doors open, to UMSL leadership attempting to broker a benefits deal that would mutually benefit the community and the University. Yet, in each interview, we heard that the conditions and factors at hand—disinvestment, White flight, bottom line capitalism—won the day in the case of health care in the Black community in and around Normandy.

Economic Stability and Income and Wealth

Having the Normandy Osteopathic Hospital in the community was seen as a benefit. It was an attraction for people to move to the area. As frequently noted in the data, Normandy Hospital was perceived as an anchor in the community. Charlie Dooley remarked:

That's one of the reasons why a lot of people that now live in the area were attracted to this area because of the hospital and the university. Those are good, what you call anchors, for any community. So if you got a hospital in your community and the university...that speaks well for your community and gives added value.

Betty Van Uum noted the attraction because Normandy Hospital was both a training center and a healthcare provider. She reflected, "We had a lot of medical services and medical people living in the neighborhood...because of the *presence* of the hospital."

Living and Working Nearby- "What about the payroll?"

The closing of the hospital changed the economic stability of the neighborhood. Dr. Knapp spoke to the "loss of income to the working staff at the hospital. You know, most of them lived in the area and, I don't know the numbers, but the hospital employed a lot of people, you know, and so the loss of those jobs into the area had a tremendous impact on economic impact in the area." Dr. Spezia reiterated this assertion.

But what did we have, like 110 full time equivalents? So they're the economy.

What about the payroll? All of these patients, all of these workers getting a paycheck. They're paying taxes, they're living in homes here in North County, and Normandy, in Northwoods and Bel-Nor, Bellerive Acres. And what happened

to those full-time equivalents? They had to go elsewhere. So, Normandy had a direct hit, you know just economically, just from the payroll that went out to the folks that worked here at the hospital. So, that was one major impact that, you can't deny that. It also had an impact with, with the ambulance services. And their part of their income was coming from transportation to the hospital, and then the transfer rigs that took our patients from the North to the South hospital. Again, cab service. There's a lot of ancillary services that just went away because the hospital wasn't there anymore.

As the community changed with job loss from the hospital closure so did the personal income and wealth of people in the community. Income refers to the annual earnings from employment and other assistance that leads to the capacity to build wealth. Wealth is a measure of stability and an accumulation of assets. Wealth affects access to financial resources and healthy communities. As described in Table 1:

Wealth measured at a single point in time may provide a more complete picture of a person's economic resources. Access to financial resources, be it income or wealth, affects health by safeguarding individuals against large medical bills while also making available more preventive health measures such as access to healthy neighborhoods, homes, land uses, and parks. (National Academies of Sciences, Engineering, and Medicine, 2017, p. 118)

Homeownership is one measurement of wealth. Charlie Dooley spoke to this in his statement.

And the old saying, if my house was someplace else it'd be ten times the value than it is here. That makes a difference in people's lives. It's what you call

generational wealth. Okay, most people's wealth, the average person's wealth comes from the home. If your home is not valued, you don't have a lot of value. And remember I don't care what people say. In America, most Americans middle class or lower middle class live paycheck to paycheck. Don't ever fool yourself. They're paycheck to paycheck. The value is in their home.

Neighborhood and Built Environment- “Just a lot of things aren't here anymore that used to be here...we used to be great!”

Personal wealth also connects to community wealth in the physical environments of the community (a.k.a. built environment) and the participants spoke to this throughout the interview process. As previously noted, there were many ancillary medical services that were available in the community when the hospital was there. However, that changed as Terry Gannon explained:

When the doctors leave and they take their business and the pharmacies leave and they take their businesses, and then those buildings are kinda like abandoned. Westlake pharmacy left. I think Beverly Hills pharmacy is still there--they're doing really good. Niemeyer pharmacy, closed. Blunkers closed. So, you know, those little, you know, five and dime drug stores, they just left. And you don't, because there weren't any doctors here anymore. Logan was gone so we didn't have chiropractors, and we didn't have osteopaths. So, you know it, it, I think it affected us.

Most affluent communities have an abundance of resources for their residents. In disadvantaged communities, those resources are limited when institutions depart. In many places across the United States, the presence of a hospital generates revenue for the

surrounding community. Some would say that institutions assist with stabilizing neighborhoods (Greenberg et al., 2019). In reflecting on Normandy Hospital, Dr. Knapp noted his belief that, “It stabilized the community in the area, you know, for a long period of time.”

When Charlie Dooley talked about the economic impact on the community, he recalled how the closure of the Normandy Hospital caused what he termed a “domino effect” with subsequent closures of other businesses.

Again, we have restaurants along Natural Bridge...what was that, the Greek restaurant? That place [Spiros]. Yeah, the University, the doctors, the realtors, they had lunch and dinner there. It's not there anymore, it's gone, it's moved to West County. The university is still here. But the hospital isn't. So, the hospital had a lot of employees, so they can afford a nice restaurant. Well, they're gone now. That money doesn't turn. A lot of the cafes, the things that we had in this area, are no longer. And that's the sad thing about this. You may not think this is strange, but think about this.

When Normandy hospital was there, we had the Greek place there. But, here's something that you don't think about how the impact it does. Look how long Goody Goody was there. More than 60 some years. And now, the people that own it now have no reason to keep it open...But what I'm saying is when you have... it's not just your community, it impacts not just next door, but the people on the [other] side of the street as well. Everybody benefited from it...All those different places was impacted with the Normandy Hospital.

“Well, in retrospect they were probably devastated,” remarked Joe Reibold when asked how the hospital closure affected the local community. In speaking about his experience working at the local bank, he elaborated:

Because a lot of the doctors banked at the Bank. A lot of doctors had small businesses—their offices. And they banked at the Bank. They also from time to time would borrow some money, so that was all good economics. When the hospital closed, I’m not sure, but there probably were 150 employees that were out of work, no longer working in the area, and so the services kind of shrank.

In a follow up about the economic impact of the hospital closure, he said:

Well, less people working, so less people buying services around the hospital, you know going to the gas station, a Quick Trip, the grocery store, or just fewer people in the, in the area. So yeah, that did certainly affect the economics... Yeah across the street from the Bank was a metropolitan insurance agency. And that was, they had a lot of salesmen, a lot of agents, and that, that closed. Superior heating and cooling bought that building, which was good, and they operated for 10 or so years and then they bought a building in Bridgeton. So that building now, I’m not sure what’s there now. But then Sherman Shell at Lucas and Hunt and Natural Bridge, you know that was a going business as well and that Shell at one point, the lot and the business, wasn’t big enough so they, they sold the Shell to a small strip mall now, I believe. And then also, you know, Drehmann-Harral had a funeral home that closed. So there’s just a lot of other small businesses. And then in our shopping center there was Western Auto which closed. There was a

National food store, which is closed, and reopened I think as a Save A Lot. So, there has not been a lot of reinvestment in the area.

When Dr. Spezia spoke about the economic impact on the community after the hospital closing, his focus was on losing the sales tax base from the other community businesses that subsequently closed. He remarked:

You know, we look at and see whether there's, is there, new construction? Not really. Is there new businesses? No. And then, so consequently, to be truthful to you because there isn't that, the communities that do surround us, the real estate tax is extremely high. Because we don't have industry paying those taxes. So, those who try to live here find themselves pain and very high real estate tax because we got to keep fire departments and police departments and services going, and so the cost is spread amongst those that will pay. And if you don't have industry or businesses, and all you have are single family dwellings or houses, that's what gets to pay. So, the sales tax has gone, or the property tax has gone up quite a bit. And that may not be a stimulus for new people moving in because they say "Well it's a lovely area, we love it, we got all this. You're central, you've got Clayton, you've got the airport, you got Westport, you're by...you've got everybody around you. But my gosh, the real estate tax is kind of high." Well, that's one reason that we can fight, because we need industry.

Terry Gannon spoke passionately about how the built environment changed after the closure of the hospital.

I think when they left, well, I still believe, just like a lot of things here--we're a food desert or a shopping desert or a health care desert. You know, just a lot of

things aren't here anymore that used to be here. They all moved West or out and why? It's not that the people don't need it. And just left us the crumbs and we're just supposed to be happy with that. I mean, I see what other communities have and, you know, parks and recreation and community centers and, you know, health facilities, and you know, all these great things. And what do we have? We used to be great.

Taking all of these things into consideration, Charlie Dooley was very clear in his assessment of the situation.

So, what I'm saying is...when you take things out of the community, you don't know the value of it once it's gone...you look back and you say, "Well, we don't have anything anymore." Well it's just a domino effect. One thing leads to another, and before you know it, your community is completely destroyed. And it's not [just] because of the hospital. This left, that left (gesturing with arms), this left, and before you know it, everybody's gone. And you're still stuck there and wonder what happened... But guess what? You still need the same services.

Community Pride and Sense of Value- "It impacts a lot about how you feel about where you live"

Building trust and collaboration is critical for the success of any community and having a true partnership with a stabilizing institution is invaluable. Dr. Spezia reflected:

It was a community that was very tight knit and there was a love of the institution. Hate to call it an institution. It was a true hospital in the sense of the word, and people would gravitate there....We'd go to the cafeteria for breakfast. There was an area, there were about four or five elderly gentlemen who would walk to the

hospital every morning as their constitutional thing to do and have breakfast. It was a meeting place. It was a place where there was camaraderie....So it was a true community, it was a true community.

Loss of access to care for physical health was a resounding theme during the interviews; however, there were additional impacts discussed that were less tangible but still salient. Interviewees spoke of emotions and psychological impacts. While these had a different tenor depending on the respondent, there was a theme of grief, and for some a feeling of devaluation. As Dr. Spezia said, "We miss it very sorely...it's impacted all of us doctors, impacted the neighborhood, impacted all of us, but you know it is sorely missed in many, many ways." Another interviewee said, "There's no longer accessible, affordable, trusted care...that's a tragedy." Perhaps Charlie Dooley spoke most passionately about the emotional impact on the community.

When you seek services outside your community, it is not the same. It is not a welcoming thing like they can way over here in our services, in our hospital.

What do you mean - *our hospital*? I'm paying too. But they don't see it that way, and so it's a psychological situation, whereas our money is alright for you, but your presence in our community is not welcome. How do you tell your kids that? How do you, how do you reconcile that? Even when I was on the County Council. How do you rectify that? When you tell people that say why they move out of our community, and you know what it is. It has nothing to do with money. I will never believe that. That's impossible to believe. People need health care. And those same people spend their money in another place, far from home. It's the same money. It is the same money! Why can't it be spent where they live? Well,

you don't choose them of being of value. So when you do that—when the majority do that to the minority—some will put less value on themselves as well. And that impacts the kids, the family structure, it impacts a lot about how you feel about where you live.

The themes that emerged from our research are summarized in Figure 2. They address the many and varied ways that the hospital served the community, the beliefs that people had on why it closed, as well as the consequences of the closure from the personal experience and insight of the interviewees.

Figure 2

Summary of Themes from Participant Interviews

| Access to Health Systems and Services | Systemic Factors | Economic Stability and Income and Wealth |
|---|---|--|
| Availability- "Having a hospital close by was invaluable to the community" | Bias and Changing Trends- "They had actually voted to move" | Living and Working Nearby- "What about the payroll?" |
| Trust- "Everybody knew where it was, how to access it, and somebody who worked there" | Systemic Racism- "All I know is that in our [Black] communities, there seems to be less investment or concern about their health" | Neighborhood and Built Environment- "Just a lot of things aren't here anymore that used to be here...we used to be great!" |
| Affiliated Services- "There were Mom and Pop pharmacies...and doctors nearby" | | Community Pride and Sense of Value- "It impacts a lot about how you feel about where you live" |
| Critical Care- "If you've got a heart attack, if you've got a stroke, time is brain, time is heart" | | |

Chapter 5: Discussion

Introduction

The purpose of this qualitative study was to examine the relationship of the closure of a health system to social determinants of health—specifically access to care as well as economic stability through income and wealth—for the Black community in one near-North suburb of St. Louis. This chapter includes a discussion of major findings as related to the literature on health equity, social determinants of health and anchor institutions. Also included is a discussion on connections to broader trends of economic disinvestment and health policy, along with recommended policy responses. The chapter concludes with a discussion of the limitations of the study and areas for future research.

The discussion and future research possibilities in this chapter help address the research question, “What has been the effect of the closure of the Normandy Osteopathic Hospital on access to medical care and for economic stability in income and wealth generation of Black residents of the Normandy municipality and bordering communities in St. Louis County?”

Summary of Key Findings

Our data showed that the closure of the Normandy Hospital affected the social determinants of health of residents in the Normandy area. Effects included reduced access to care due to lack of transportation, increased time to care, and disconnection from care providers. There was also an impact on economic stability as evidenced by the loss of residents and businesses affiliated with the hospital. Additionally, there was an impact on the community’s pride and sense of worth, given the loss of an institution that

was important to the community and something that put Normandy on par with other communities in the area.

These findings reflect the research that local hospitals are a key source of health care, as outlined by Bhatt and Bathija (2018). The experiences shared by our interviewees reflects the data that access to care is important in addressing health outcomes, especially for populations disproportionately impacted by chronic health conditions (Benchaabane, 2021; Bhatt et al., 2018; Kelly et al., 2016). Specifically, the research outlining access, as exhibited by categories including appointment availability, wait times, provider capacity, transportation and distance to providers, disease severity, health insurance, among other things (St. Louis Regional Health Commission, 2019), was clearly reflected in the recollections of Normandy residents who felt the loss of the hospital. Indeed, the definition of health inequity, as “reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment” (Illinois Academy of Family Physicians, 2020, Definitions of Health Equity section), is borne out in the description of how Normandy, as it went from a majority White community to a majority Black community, lost the community’s means to accessible, affordable, trusted medical care.

The experiences shared by our interviewees also reflected the socio-economic impact due to a loss of a stabilizing institution. This included both income and wealth, but also impacts on investment in the built environment and the impact on the culture of pride and parity in the community. As reflected in the research, anchor institutions act as stable providers in a community, providing employment and services to a community (Schwarz, 2017). Interviewees spoke to the destabilization that occurred in the loss of the

community, not only to access to services, but to the ripple effects to other businesses and to the loss of residents associated with these businesses. Moreover, interviewees spoke to the feelings of loss and a change in the sense of worth of the community that disinvestment brought. Where residents previously experienced a community that offered everything they had been looking for in a community, they were then left without critical services—while still seeing that other communities, namely in West County, had an abundance. This data suggests an impact to the community's cohesiveness and to a sense of worth experienced by a community. While the impact of disinvestment is often captured in physical health and economic outcomes, we hear less often about the social emotional impact of disinvestment on individuals' collective sense of community worth.

The qualitative research reflected through this study provides an in-depth look at the experiences of one community; however, it is reflective of the larger trends that were occurring within the medical field and within St. Louis at the time. To our knowledge, no other research has provided this kind of in-depth analysis of community residents' experiences of the loss of an anchor medical provider that served both White and Black people in a community with a majority of Black residents. These results provide qualitative evidence both to the importance of the presence of trusted, accessible medical provision, as well as the importance of medical anchors that provide stability and economic development, along with community pride and worth.

The results also speak to the myriad of factors that influence the social determinants of health in communities. As seen in the National Academies of Sciences, Engineering, and Medicine's conceptual model examined in this paper, the social determinants of health are a collection of factors that influence health equity. While this

study specifically looked at access to care and economic assets of income and wealth, we heard from interviewees across the board that factors such as transportation, employment, built environment, and education, among others, influence a community's wellbeing. Indeed, in most interviews, health was not spoken of in an isolated way, but rather in tandem with learning opportunities—such as access to UMSL—or in tandem with transportation—such as the need for adequate means to get to care. This data reflects the complexity of health equity and how it is intertwined with many other community and social factors.

While this study is reflective of the historical context within the Normandy footprint, these experiences may also point to the potential trends within other Black communities that experienced the loss of medical institutions and providers in the St. Louis region and possibly other regions as well. We heard from Normandy Hospital doctors about the changes in health care reimbursement and their efforts to adapt to health reimbursement policies. We also learned about how a Certificate of Need was secured in order to keep a hospital in the community. Additionally, the larger context of Doctors of Osteopathy being accepted and ultimately recruited by allopathic hospitals was another policy that influenced shifts in health care.

We heard Pastor B.T. Rice speak of larger trends of reduced access to medical care for Black communities within St. Louis, including the averted move of the DePaul hospital. Indeed, several interviews reflected on how consolidation and centralization of medical services impacted access and exacerbated racial inequities. In the end, community efforts were unable to retain the Normandy Hospital; however, these efforts demonstrate ways that community voice might be used more effectively to hold decision

makers accountable for health equity and equity in access to care. These experiences of community leaders reflect findings illustrated in our conceptual model—that a multisector collaboration (as evidenced by Pastor B. T. Rice’s coalition of nonprofit health and faith leaders) can be a driver for more equitable communities. The data also illustrate another component of the conceptual model, that *community-driven* solutions are key to addressing the structural inequities, socioeconomic and political drivers that undergird policy. Indeed, health policies at the time of the institution’s closing were shifting at the federal and state level and previous financial models no longer held strength. Those attempting to keep the hospital open were drawing on both community voice as well as political will. While these efforts in the end did not sustain the hospital, they contributed to the larger push for equitable health care that continues today. Therefore, an important area of reflection is how this research can influence current policies.

Recommendations

Lessons learned from our research include ways to improve access to care as well as ways to strengthen economic investments in communities that have experienced disinvestment. Further, they lend themselves to the importance of incorporating community voice and priorities into the policy-making context.

Our research showed that individuals experienced a shift in their access to care after the departure of the hospital. Residents had previously experienced an affordable, trusted, and accessible medical facility that served a range of needs. We also heard that the outcropping of urgent care centers since that time has not gained enough acceptance in the Black community to replace the trusted care that was received at Normandy

Hospital. Community leaders need to consider what new options for trusted, accessible, and affordable care may emerge to better serve Normandy (and communities like Normandy). These may include birthing centers focused on the reduction of racial inequities in maternal and infant mortality. These may also include community health workers, patient navigators, or other trusted community leaders who can broker access and trust within Black communities disproportionately impacted by chronic diseases and, most recently, COVID-19. A Community Health Worker (CHW) may be a viable solution. A CHW is a trusted member of the community in which they serve, allowing them to act as an intermediary between the community and several industries, including healthcare, criminal justice, education, and social services.

The cultural sensitivity and trauma-informed delivery of care provided by a CHW aids in not only improving the health status for individuals and communities, but also for building community capacity and self-sufficiency within residents of the same communities negatively affected by compounding social determinants. Our research points to the need for trusted medical care located within a reasonable proximity as a key priority for preventative care by having a medical home, and a better chance at keeping medical appointments. Community leadership and voice—in the early stages, not just after decisions have been made—as well as multi-sector coalitions between government, anchor institutions, and local businesses and nonprofits should be key partners in furthering these efforts of health equity. We encourage further action and research to determine ways to bring more accessible health care back to the Normandy and surrounding communities.

Not only did we hear about the importance of access to care, but we also heard about the impact of disinvestment in the community and the importance of how institutions strengthen neighborhoods. Spurring the loss of ancillary businesses such as pharmacies and other retail, as well as some residents, the loss of the hospital impacted the community's economic base including lost revenue from taxes. This leaves a community open to harm. While we did not explore the management of the Normandy Hospital in-depth, our interviewees spoke about being taken advantage of by outside interests, including a medical management firm located in Texas. This data suggests the need for making health equity a shared vision and value for stakeholders who build their businesses or services in the Normandy footprint. It also points to the need for more accountability to those shared values and the need for strategic investments in the Black community, focusing on generating revenue in and for the community. A shared vision must be developed in partnership with residents, business owners and community stakeholders. This engagement takes time to develop and requires community input while building trust and actionable items for accountability and transparency. The vision for the community most often is built into community plans that are then adopted by the community and their governmental structure.

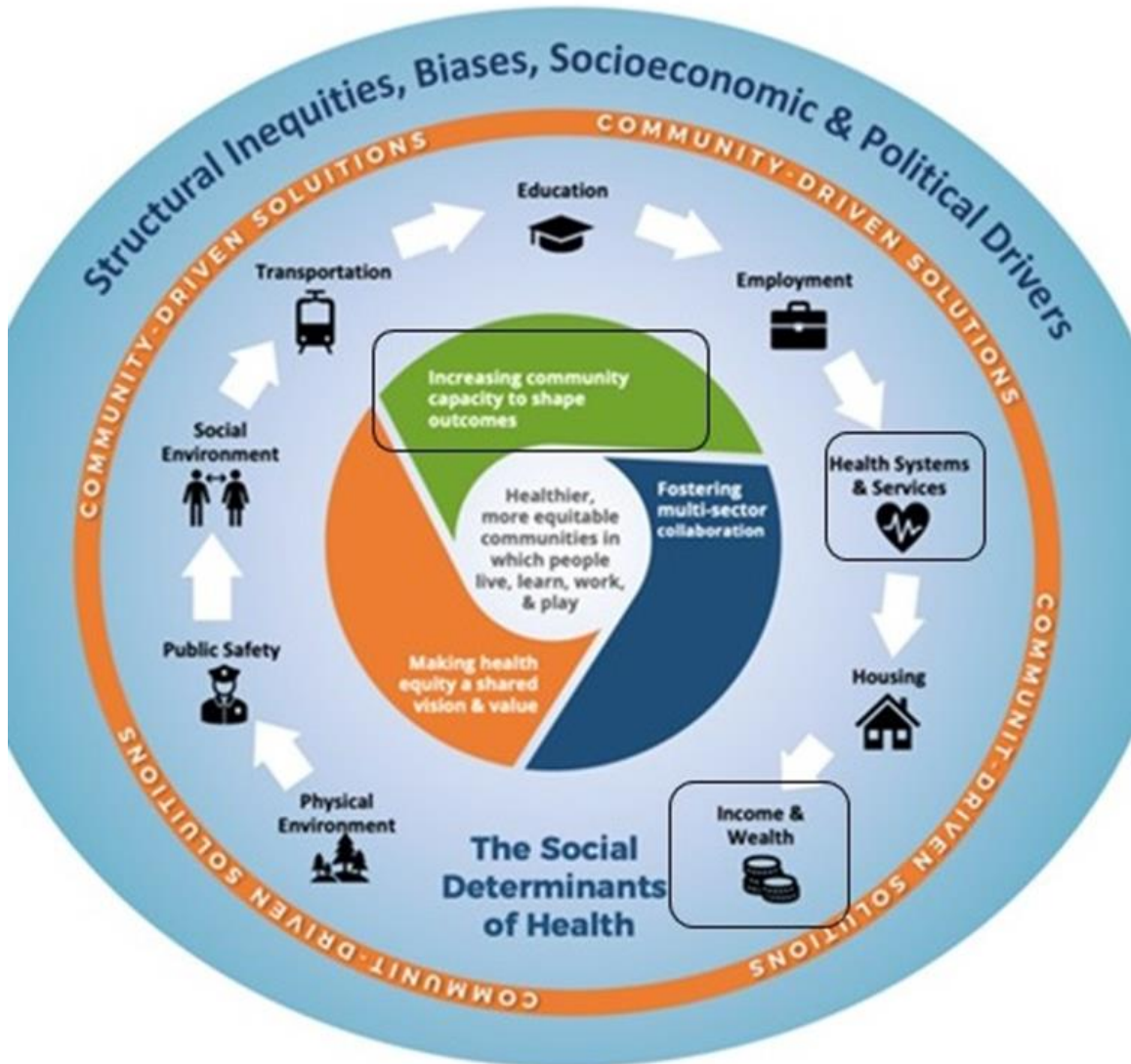
Further, it calls for a comprehensive approach to these investments that prioritize residents and communities, and builds complementary ecosystems for residents to benefit economically. Policy plays a critical role in advancing the community's needs and thinking about health in all policies, including community development, transportation, and education. Transformative change in the community does not happen without cross-sector partnerships that hold space for understanding the community's needs. There is a

need to invest for social impact, to push social change forward, and to address the root causes and determinants of issues that have negatively affected many Black communities. The collective impact is enhanced with integration and elevation of the people closest to the issues. Community residents have wisdom and clarity in their collective agenda. They need the tools to share that wisdom and to remove barriers to access.

To build power within the community and to inform decisions and broker accountability with medical care partners and other businesses, a focus on building leadership capacity is necessary to ensure that community leaders have the knowledge, skills, and networks to hold businesses and medical care providers accountable to the needs of the community. We heard Pastor Rice talk about the difference that his coalition's power made in keeping DePaul from moving, even though they were not able to have the same results with keeping the Normandy Hospital open. When the final decisions were made to close the hospitals, DePaul's leadership was located in St. Louis with a mission to serve St. Louis; while at the time the Normandy Hospital was being managed by a firm in Texas. This points to the need for local leadership and local investment in a way that creates economic growth and wealth for Normandy and the surrounding communities. These points are reflected in the conceptual model shared earlier in our dissertation in Figure 1.

Figure 3

Revisited Conceptual Model for Community-Based Solutions to Promote Health Equity



Note. This is the same as Figure 1 from the National Academies of Sciences, Engineering, and Medicine, 2017, with boxes added to highlight concepts pertaining to our interviews.

Some specific policies and programs that may increase investment and address the disinvestment that has occurred in Normandy and the surrounding communities

include community benefits agreements, anchor accountability measures, and continued strengthening of community leaders and community voice.

As part of a community strategy for overall investment and development, neighborhood control should be encouraged and stressed in every community area, especially in distressed or historically disinvested areas. This can be achieved by financially supporting local organizations, granting ownership of properties, and completing neighborhood plans to identify transformative investments. Another action step is for partnering organizations to provide housing assistance with a commitment to permanent affordability.

Concentrated investment around existing transit lines can help improve and strengthen neighborhood mobility connections and workforce mobility. Government systems must transition their relationship with real estate development to one that works with the community to achieve mutual benefit. Leveraging real estate development as an economic engine can drive a robust and resilient economy through equitable, transparent, and accountable incentive models.

The goal of economic development incentives should be to create mutually beneficial partnerships between developers and the community. If public funds are invested in a private project, the community must realize a positive rate of return in the form of community benefits, jobs, and tax revenue to fund public service.

Utilizing incentives to facilitate impactful development is arguably the government's most powerful tool. It is a tool that can easily be abused by providing too many benefits to a developer and taking away valuable resources from the community. Government must work together with school districts and other taxing bodies to use

incentives responsibly to minimize the negative impact on the community, grow the economy, and add new residents to the community.

Community Benefits Agreements (CBAs), which are contracts between communities and developers, along with policy measures are also critically important to ensure the long-term sustainability of the community revitalization. Community benefits lists are examples of agreement terms designed to meet the needs of any community. Most lists from various cities are merely suggestions of possible options depending on the unique strengths, vision, and growth needed for the impacted community. It is recommended that as part of any neighborhood planning process, a list of CBA options is generated specifically for certain areas based on their uniqueness.

This targeted approach will help guide the negotiations process with developers to ensure benefits are appropriately responsive to community needs. CBAs should incentivize projects per the strategies outlined by a community and neighborhood plan. CBAs along with government entities should encourage contributions to such things as affordable housing, infrastructure improvements, mandated hiring practices, or other community-identified needs such as health care access. In this way, communities will have targeted reinvestment paired with the achievement of community goals and the fulfillment of addressing community need.

Equitable St. Louis Coalition's guide for CBAs states that included benefits "should be informed by the neighborhood impact assessment and feedback from community activities. These could fit under categories including Quality of Life, Environmental or Health Impacts, Housing, or Workforce, and are informed by the

demographics of the neighborhood” (Equitable St. Louis Coalition, 2018, p. 4). It then outlines the sections that should be included in a CBA as:

- Recitals: This section provides a brief background on the agreement
- Definitions: This section defines key terms used throughout the agreement
- Agreement: This section lays out the specific commitments and obligations of all signatories, —organizations signing on to the CBA — including the developer, community representatives, and whoever else may have been a part of the negotiating process.
- Enforcement: This section describes in detail the process for enforcing the CBA, to make sure that all agreed commitments are being upheld. This is where the process for legal enforcement is laid out should the developer or the community not hold up their end of the CBA. It often includes a notice period where problems can be handled before entering the enforcement period, where legal consequences can be pursued.
- Termination: This section details the conditions under which the CBA can be terminated. This commonly includes two situations — terminating the CBA because it has reached its expiration date, and cancelling the CBA because the project was not approved by the government’s development review committee(s).
- Implementation: This section describes in detail exactly how the CBA will be carried out. It includes items like who is considered a valid signatory, how the CBA applies to contractors and sub-contractors, as well as other considerations. (Equitable St. Louis Coalition, 2018, p. 6)

As noted on the Health Landscape website about social determinants of health, they “shape public health and policy interventions. Neighborhood socioeconomic and demographic characteristics play significant roles in influencing health outcomes. People coming from economically disadvantaged neighborhoods and minority groups are at higher risk for a number of health conditions” (American Academy of Family Physicians, 2021, Community Data and Research section). The socioeconomic wellbeing of residents will impact their health outcomes, and community benefits agreements allow for residents to also benefit from investment and advance economic mobility. As previously stated, a comprehensive and holistic approach to community and economic development determines how to mobilize systems, people, places, and power to better those involved.

During the Healthy Neighborhood Investments: Policy Convening for Advancing Health and Racial Equity, participants called out specific policy actions that governments can take to advance racial and health equity. Below are a few examples of policy opportunities that communities can adopt when thinking about health equity and the wealth of community residents as outlined on the *Building Healthy Places: Charting California’s Path to Racial and Health Equity Centering Belonging and Civic Muscle in Policy* brief:

- Use current state budget situation and Rescue Act funds to A) make permanent innovations tested during the pandemic, and B) practice community-centered and participatory budgeting via state and regional-level planning and allocations, and evaluate the impact of temporary COVID-19 measures (e.g., unemployment benefits increasing or decreasing employment;

eviction prevention increasing or decreasing housing stability and affordability).

- Create a package of anti-displacement policies and investments in affordable housing.
- Reduce the disparities in birth outcomes for Black moms (e.g., Formalize doulas/midwives as part of a maternal healthcare team statewide and legalize them to practice independently in home births, hospitals, etc.).
- Invest in healthy food systems that grow local, sustainable, regenerative small farmer ecosystems.
- Incentivize healthcare to invest in the community and the social determinants of health (e.g., Incentives built into MediCal RFPs; a version of the Community Reinvestment Act for insurers; Mandates for community investment and engagement; Build on FQHCs required to have 51% of community representation to lift and center diverse voices in funding and decision making.)
- Require standardized and aligned community health needs assessments across sectors as a requirement for funding) and shift healthcare institution dollars toward community-driven collaborations.
- Create a statewide Health Information Exchange and public utility Community Information Exchange, including social determinants of health, race, and ethnicity, and other forms of disaggregated data.
- Rebuild the capacity of communities to respond to health needs. (Build Healthy Places Network, 2021, p. 6)

These policy recommendations, complemented by the community benefits agreement, begin to transform people in place. The power of resident engagement and awareness of what is happening in the community is critical for a successful project.

Suggestions for Future Research

There are many topics that came up in our study that are opportunities for further research. While the Normandy hospital's identity within the osteopathic field was noted in the interviews, we did not inquire about this specific context with our interviewees. The closure of the Normandy hospital was certainly part of a larger trajectory for osteopathic hospitals in general. Our study aimed to focus on the impact of the closure of a hospital within a Black community near St. Louis; however, we recognize that further research may be useful to understand the closure of the hospital within larger trends for osteopathy overall.

Another area for future research that emerged was individuals' reports of community worth and value. According to our data, disinvestment impacts physical health and economic outcomes, and a community's sense of pride and value. This finding, too, ties directly to critical social determinants of health. Our conceptual model shows health equity as a shared value essential to achieving health outcomes. To achieve a shared regional vision, institutions or other communities must value communities other than their own. This value has policy implications that need to be further explored and researched to inform ways to address these experiences for communities most impacted by disinvestment.

While our research points to the importance of, and need for access to affordable, trusted medical care, we recognize the need for community voices and prioritization to

determine what investments and services will best serve Normandy and nearby neighborhoods that will address the gaps created with the departure of the hospital. We hope our research efforts (including the interviews that are available for review as oral histories on the UMSL Digital Humanities website at <http://umsldigitalhumanities.org/perspectives-the-impact-of-the-closure-of-normandy-osteopathic-hospital-on-the-surrounding-community/>) will contribute to a vision of healthier, more equitable places in which individuals and families can live, learn, work, and play in Normandy and the surrounding communities.

Conclusion

Systemic racism that has led to the reduction of access to care and economic stability in many Black communities directly influences the social determinants of health. This study shines a light on the lived experience of residents in one community experiencing the loss of a key medical provider and serves to unearth the layers of disinvestment over time—reimbursement rates, provider selection processes, the exploitation and subsequent departure of investors. Ultimately, this disinvestment contributed to decreased access to medical care experienced by residents of one predominantly Black community in North St. Louis County. Furthermore, our data shows that disinvestment, such as hospital closures, not only impact the physical health, but also the sense of worth, value, and importance claimed by the community. Given the dearth of information on the closures of the Normandy Osteopathic Hospital, we hope this study has shed light on a relatively unexplored event, as well as opened the door for further research into how hospital closures impact the social determinants of health in Black communities. As the St. Louis region grapples with its history of systemic racism, we

hope the data gathered here can contribute to a strong response by local governments and anchor institutions to address the disinvestment documented in this study and to increase access to medical care and improve economic stability for both the Black community in the Normandy footprint, as well as the larger region of St. Louis.

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Appendix A

Consent Form



One University Boulevard
 St. Louis, Missouri 63121-4499
 Telephone: 314-516-5897

Informed Consent for Participation in Research Activities

Study title:

Perspectives: The Impact of the Closure of a Health Institution in the Black Community in North St. Louis County

Participant _____ HSC Approval Number ____2076166____

Principal Investigator _Erica Henderson _____ PI's Phone Number_314-578-7227 _____

Summary of the Study

Brief description of the project-

The title of this study is *Perspectives: The Impact of the Closure of a Health Institution in the Black Community in North St. Louis County*. The purpose of this research study is to examine the relationship of the closure of a health system to the social determinants of health for the Black community in one near-North suburb of St. Louis. Specifically, the study will focus on the closure of the Normandy Osteopathic Hospital which was located in Normandy, MO.

1. You are invited to participate in a research study conducted by Kiley Bednar, Erica Henderson, Andrea Jackson-Jennings, Patricia Zahn, University of Missouri-St. Louis graduate students and Dr. Theresa Coble, University of Missouri-St. Louis professor and graduate advisor. The purpose of this research, as previously stated above, is to examine the relationship of the closure the Normandy Hospital to the social determinants of health.

2. Your participation will involve:
 - a) One video and audio recorded interview that will be transcribed.

Interviewees will be asked a series of questions to gain their perspectives of their experiences related to the closing and impact of the closing of Normandy Hospital. The research team will review these shared stories and compare them for any commonalities as well as points of concern and opportunity. A copy of the interview will be made available to each interviewee. Unless the interviewee decides otherwise, the interview recordings will be posted on the UMSL Digital Humanities web resource as an open resource. If the interviewee chooses not to have the interview made publicly available, the interview recording will be kept in a safe, confidential site with access only to the researchers and other authorized UMSL personnel and destroyed at a later date per research protocol.

Please provide a signature for one of the below options:

_____ YES, I provide permission for my recorded interview to be posted on the UMSL Digital Humanities website.

_____ NO, I DO NOT provide permission for my recorded interview to be posted on the UMSL Digital Humanities website.

Approximately 12 people may be involved in this research with the University of Missouri-St. Louis. The interviews will take place over Zoom unless the participant prefers in-person meeting.

b) The amount of time involved in your participation will be 45 to 90 minutes for the interview.

3. Please note that there is a loss of confidentiality risk. See no. 7 below for how this risk will be minimized.
4. There are no direct benefits for you participating in this study. However, your participation will contribute to the body of educational knowledge.
5. As noted above, a copy of the interview will be made available to each interviewee for review.

6. Your participation is voluntary and you may choose not to participate in this research study or withdraw your consent at any time. You will NOT be penalized in any way should you choose not to participate or withdraw.

7. As noted above, unless you, the interviewee, decides otherwise, the interview recordings will be posted on the UMSL Digital Humanities web resource as an open resource. If the interviewee chooses not to have the interview made publicly available, the interview recording will be kept in a safe, confidential site with access only to the researchers and other authorized UMSL personnel and destroyed at a later date per research protocol. Further, we will do everything we can to protect your privacy. As part of this effort, your identity will not be revealed in any publication that may result from this study. In rare instances, a researcher's study must undergo an audit or program evaluation by an oversight agency (such as the Office for Human Research Protection) that would lead to disclosure of your data as well as any other information collected by the researcher. However, your name will not remain linked with your responses, a pseudonym will be assigned, and will be stored in a separate file so we can verify you have participated.

8. If you have any questions or concerns regarding this study, or if any problems arise, you may call the Primary Investigator Erica Henderson at 314-578-7227 or the Faculty Advisor, Dr. Theresa Coble 314-516-5951. You may also ask questions or state concerns regarding your rights as a research participant to the Office of Research, at 516-5897.

I have read this consent form and have been given the opportunity to ask questions. I will also be given a copy of this consent form for my records. I hereby consent to my participation in the research described above.

| | |
|-------------------------|------|
| | |
| Participant's Signature | Date |

| | |
|---------------------------------------|------|
| | |
| Signature of Investigator or Designee | Date |

Date of Interview: March , 2022

Appendix B

Script for Interviewee Recruitment

Hello!

Our names are Kiley Bednar, Erica Henderson, Andrea Jackson, and Patricia Zahn. We are graduate students at the University of Missouri-St. Louis in the College of Education. Our dissertation team is conducting research on the closure of Normandy Osteopathic Hospital. We understand that you have a connection to the hospital as someone who either worked there, or you are someone who lived or worked in the community surrounding the hospital during or around the time of the closure.

We hope you will consider helping us learn about the effects of the closure of the hospital in the community. We will be conducting oral history interviews for this research project. Participation in this project involves an one-hour recorded interview where participants will answer about 10 questions.

Please respond to this message to let us know if you are interested in participating, or if you would like additional information.

Thank you!

Appendix C

IRB Approval

January 28, 2022

Principal Investigator: Erica Lynne Henderson (UMSL-Student)

Department: Education EDD-Doctorate

Your IRB Application to project entitled Perspectives: The Impact of the Closure of a Health Institution in the Black Community in North St. Louis County was reviewed and approved by the UMSL Institutional Review Board according to the terms and conditions described below:

| | |
|---|---|
| IRB Project Number | 2076166 |
| IRB Review Number | 347699 |
| Initial Application Approval Date | January 28, 2022 |
| IRB Expiration Date | January 28, 2023 |
| Level of Review | Exempt |
| Project Status | Active - Exempt |
| Exempt Categories (Revised Common Rule) 45 CFR 46.104d(2)(ii) | |
| Risk Level | Minimal Risk |
| | Revised Consent |
| Approved Documents | questions for the interviews interviewee recruitment email |

The principal investigator (PI) is responsible for all aspects and conduct of this study.

The PI must comply with the following conditions of the approval:

1. Enrollment and study related procedures must remain in compliance with the University of Missouri regulations related to interaction with human participants following guidance at <http://www.umsl.edu/recd/compliance/umsl-guidance-covid19-policy-7.2021.pdf>.
2. No subjects may be involved in any study procedure prior to the IRB approval date or after the expiration date.
3. All changes must be IRB approved prior to implementation utilizing the Exempt Amendment Form.
4. The Annual Exempt Form must be submitted to the IRB for review and approval at least 30 days prior to the project expiration date to keep the study active or to close it.
5. Maintain all research records for a period of seven years from the project completion date.

If you are offering subject payments and would like more information about research participant payments, please click here to view the UM Policy:

https://www.umsystem.edu/ums/policies/finance/payments_to_research_study_participants

If you have any questions or concerns, please contact the UMSL IRB Office at 314-516-5972 or email to irb@umsl.edu.

Thank you,

UMSL Institutional Review Board

Appendix D

Interview Guide

*Perspectives: The Impact of the Closure of a Health Institution
in a Black Community in North St. Louis County*

Script is in BLACK font

Notes for interviewer are in RED font

SCRIPT

Thank you for taking time to meet with us today. As we shared earlier, we are a research team of doctoral students at the University of Missouri- St. Louis and we are exploring how the closure of the Normandy Osteopathic Hospital affected the health and economic well-being of the people and community in which the hospital was located.

Our interview today will take about an hour or so and we are recording the interview.

Because we have had difficulty finding information about the hospital closure, we believe that your interview will provide important perspective and context to this event. The plan is to host your interview, or oral history, on the UMSL Digital Humanities website so others can learn from you. Our dissertation team will be conducting a dozen or so interviews and will be reviewing and writing about our understanding of the effects of the closure of the hospital.

We have about nine (9) questions to go over with you in our short time together.

After the interviews are complete, we will share a link to the interview for your review before we post it publicly.

We have a release form that I will **go over with you now**, and we have emailed to you to sign and return. Further, we ask that you verbally acknowledge your understanding now.

(Interviewer goes over information on the release form and gets verbal acknowledgement to proceed.)

To start, we will introduce ourselves and then ask you to state your name and then your affiliation with Normandy Hospital.

Any questions before we begin to record?

PRESS “Record” button

Lead into asking the following questions.

QUESTIONS

- Please state your name for the recording.
- How were you affiliated with Normandy Hospital?
- What types of services and activities were offered at the hospital?
- How do you believe the hospital affected your health and well-being personally?
- How do you believe the hospital affected the health and well-being of the members of the community?

- Why do you believe the hospital closed?
- After the hospital closed, what do you think the effects were on the community?
- How did the closure affect access to healthcare for community members?
- What, if any, do you think was the economic impact of the hospital closure?

A closing, or wrap up question can be something like:

- Is there anything else that you would like to share that you think people should know about the hospital closure?

End the interview with a “thank you.”

PRESS “End Recording” button.

Then restate how the information will be housed and see if there are any further questions about the dissertation process.

Ask if there is anyone else who they would recommend us to interview who might provide another perspective.

Thank the interviewee again and end meeting.

Reminder note for interviewers: Interviewers must be sure to ask question and then just listen. No nodding or “yes” etc. It is fine to follow up with brief questions for clarification or to bring the interviewee back to topic if they stray.

Listening is the most important skill in interviewing” (Seidman, 2006, p. 78). Active listening is necessary while making sure not to interrupt, or provide reinforcement like head nodding, or saying “yes.” Instead, researchers should listen with interest and wait for the interviewee to finish speaking before asking a clarifying question, probing for more on that topic, or moving to the next question. Seidman (2006) notes that it is important to ask for more information if the interviewer thinks that there are more details that the interviewee can provide that would be helpful to the exploration. Seidman (2006) also talks about tolerating silence in the interview session. Sometimes people need to take time to pull their thoughts together or reflect.

If they ask for the recording to stop, then the recording should stop. “If the person relates information that could potentially harm their job or immigration status, it is your duty to warn them that in oral history, there is no such thing as "lawyer-client privilege" and that interviews can be subpoenaed by courts. It is appropriate to erase parts of a recording that contains sensitive information before turning it over to a library or archive” (Ortiz, 2014, p. 6).