2020

Lived Experiences of African Americans 65 and Older After Rural Hospital Closures

Derrick Mike
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Derrick Mike

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Cynthia Newell, Committee Chairperson, Health Services Faculty
Dr. Ronald Hudak, Committee Member, Health Services Faculty
Dr. Suzanne Richins, University Reviewer, Health Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2019

Abstract

Lived Experiences of African Americans 65 and Older After Rural Hospital Closures

by

Derrick Mike

MBA, Westwood College, 2014

BS, Westwood College, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Sciences

Walden University

November 2019

Abstract

African Americans 65 and older have had varied experiences due to losing immediate access to nearby hospitals for urgent treatment for emergency medical conditions. This phenomenological study was conducted to explore the lived experiences of those residing in areas after a rural hospital closure occurred. The hospital was the primary and nearest facility for receiving immediate access to urgent treatment. The research questions focused on the encounters experienced by the participants after the hospital closure. The Health Belief Model was the conceptual framework used for this study. The method and data analysis procedures included interviews, field notes, a life-course chart, and specified demographic information. Eight African Americans 65 and older from Webster and Stewart County Georgia were interviewed. The other inclusion criteria were the participants' previously being treated for an emergency medical condition at Stewart Webster Hospital at least 1 year before the hospital closure and at another hospital at least 1 year after the hospital closure. The results of this research were that the participants encountered negative experiences on a higher level than positive experiences with accessing immediate treatment. Also, participants encountered and needed to make various, and undue changes to receive treatment for the critical medical condition treatment. The positive social change significance included providing information on experiences encountered by the participants after rural hospital closures and suggestions for others in rural areas to prepare for hospital closures. Moreover, this research could help state, local, and federal agencies provide alternatives for immediate treatment for emergency medical conditions in other rural towns after hospital closures occurred.

Lived Experiences of African Americans 65 and Older After Rural Hospital Closures

by

Derrick Mike

MBA, Westwood College, 2014

BS, Westwood College, 2012

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Sciences

Walden University

December 2020

Table of Contents

Chapter 1: Introduction to the Study

In the United States, the population of those age 65 and over is projected to reach 83.7 million, almost double the population of 43.1 million in 2012 (Kudo, Mutisya, & Nagao, 2015). The baby boomers are primarily responsible for this increase in the older population, as they began turning 65 in 2011 and by 2050 will be over the age of 85 (Kim, Lee, Cheon, Hong, & Chang, 2018). The proportion of baby boomers is higher in rural areas than in urban areas, and their numbers are expected to increase in the next decade (Johnson, & Lian, 2018). Baby boomers residing in rural areas experiencing emergency medical conditions may require closer access to medical treatment. Moreover, their access to health care options will also become relevant to their survival as their age increases (Bragg, & Hansen, 2015). For example, a woman who is 68 could fall and be hurt badly. These and other types of medical emergencies cause a need for immediate access to a nearby hospital for medical treatment, but there are often hospital closures in rural areas, which disproportionately affects elderly residents (Burkey, Bhadury, Eiselt, & Toyoglu, 2017).

Hospitals in rural areas predominantly serve nearby communities, and their closures cause adverse health-related outcomes (Balasubramanian & Jones, 2016). Rural hospitals provide closer and quality health care alternatives and options (Pati, Gaines, & Valipoor, 2016), and closures have caused adverse health care outcomes for those living nearby with treatable medical conditions (Zimmermann, Carnahan, Paulsey, & Molina, 2016). For instance, elderly residents have had challenges such as maintaining optimal health care outcomes and having nearby proximity to medical treatment (Countouris,

Gilmore, & Yonas, 2014; Vergunst, Swartz, Mji, MacLachlan, & Mannan, 2015), which causes health disparities due to their lack of nearby access to medical treatment (Bischoff, Springer, & Taylor, 2017; Yamada et al., 2015).

Some elderly populations living in rural areas have also faced disadvantages due to their social and economic status, which created health care barriers caused by their loss of access (Ford, Wong, Jones, & Steel, 2016). Health care disparities have occurred when there were differences in access to a nearby hospital or when a population has experienced a lack of access to a nearby hospital (Scanlan, 2014; Gittner, Clochesy, Gutierrez, & Robinson, 2015).

Health care disparities have occurred with genders as well as ethnic and racial groups that have limited their ability to access for treatment that could have improved their health care outcomes (Thomas, 2014). The health of a community with higher populations of a specific gender, ethnic, or racial group encounters higher risks for declining health when rural hospitals close (Brame, 2017). Therefore, hospital closures in rural areas have affected the most populated race and ethnicity residing there (Thomas, Holmes & Pink, 2016).

Elderly African Americans have been impacted more by hospital closures in rural areas because they comprised the highest population (Usha & Lalitha, 2016). For example, the hospital that was serving both Stewart and Webster County in Georgia closed. Stewart and Webster County were collectively composed of 89% African Americans, and 28% were 65 and older (Suburban stats, 2017). The hospital closure created a loss of immediate access to a nearby hospital for emergency medical treatment

with the residents of Stewart and Webster County. In response to this problem, I explored the lived experiences of African Americans 65 years of age and older who had been treated for previous emergency medical conditions and resided in Stewart and Webster County after the hospital closure. The objective of this study was to explore the participants' experiences related to seeking immediate medical treatment or alternatives not located in the town and the impact of hospital closures in relation to their medical condition.

Background for the Study

The lived experiences of African Americans 65 years of age and older residing in Stewart and Webster County, Georgia after the hospital closure warranted exploring four areas: (a) residential and population statistics for the state of Georgia, (b) some rural area statistics associated with African Americans 65 years of age and older, (c) a possible cause of Georgia rural hospital closures, and (d) the positive aspects of having a hospital close to their homes. These 4 areas provided fundamental information relevant to this study. I explored the topics using statistical, historical, and cultural data to discover the overall dynamics of the participants.

Hospitals in rural towns are close sources for immediate treatment for emergency medical conditions (Price et al., 2016), so hospital closures cause lack of access for emergency medical treatment for those residing in rural areas (Holmes, 2014). Rural hospital closures affect residents 60 and older because they constitute a larger population in many rural areas (Baernholdt, Yan, Hinton, Rose, & Mattos, 2012). For instance, the elderly population in rural cities in the United States was the majority age group in 2011

(Lichter, Parisi, & Taquino, 2012). Elderly populations in rural areas who are living a better quality of life tend to have nearby connections to health care treatment, positive social involvement, and closer access for receiving and strengthening their health care options for medical treatment (Baernholdt et al., 2012). Positive health-related outcomes in rural communities are influenced by the presence of a nearby hospital or health care facility for immediate access to emergency medical treatment (Prina, 2016).

Between January 2010 and July 2017, six hospitals located in rural areas in Georgia closed (Iglehart, 2018). Although the cause of these hospital closures is unknown, not participating in the Medicaid expansion program of the Affordable Care Act may be a reason. States that did not participate in the Medicaid expansion program experienced financial shortfalls in rural area care (Price & Eibner, 2013). There were provisions of the Affordable Care Act implemented for states to engage in Medicaid expansion that were income based and established to expand coverage for adults 65 and older and individuals at or below the defined poverty level (Hamel, Blumenthal, & Collins, 2014; Jost, 2016). Although these provisions were part of the Affordable Care Act, the Medicaid expansion portion was optional and not mandatory (Epstein, Sommers, Kuznetsov, & Blendon, 2014).

States that decided not to participate in the Medicaid expansion portion lost their privileges to receive Medicaid allotments (Eaton, & Mugavero, 2016), which were distributed to hospitals that served a large number of patients who received Medicaid or had no insurance. The hospitals receiving Medicaid allotment also had to qualify because the money was the disproportionate share hospital portion of Medicaid funds (Chokshi,

Chang, & Wilson, 2016). The state of Georgia under the leadership of Governor Nathan Deal did not accept the Medicaid expansion portion of the Affordable Care Act, so Georgia did not receive Medicaid allotment (Barrilleaux, & Rainey, 2014). The result of this rejection caused Georgia rural hospitals to lose millions of dollars for health care and medical services rendered to their patients (Sommers, Kenney, & Epstein, 2014).

The Georgia Consumer and Community Group had issues with Governor Deal rejecting the Medicaid expansion. Their problem was not only based on the 400,000 Georgia residents who would be affected but the limited access to medical treatment for residents in rural areas (Georgia Consumer and Community Groups, 2014). The group had relative concerns for elderly populations living in rural towns who would not have immediate and nearby hospital access, which was a necessity for receiving prompt medical treatment.

The Georgia Consumer and Community Group gave recommendations for accepting Medicaid expansion to Georgia policymakers, including Governor Deal, but Governor Deal still opted out of participating with Medicaid expansion. This led to hospital closures in rural parts of Georgia, which was second only to Texas. The primary difference is that all hospital closures in Georgia primarily effected the residents in or near rural towns (Reiter, Noles, & Pink, 2015). People who encountered limitations with nearer access to emergency services had poor health outcomes (Fleet et al., 2014).

After Georgia rural hospitals closures from 2013–2014, Governor Deal created health care treatment alternatives. The alternatives were intended to help ease the burden of hospital closures in Georgia’s rural areas (Herman, 2014). The plans included

implementing emergency room services only in rural hospitals closed for a year or less (Robeznieks, 2014). However, the plans did not provide any alternative options for nearby treatment with emergency medical treatment in rural areas of Georgia where hospitals closures had occurred for a year or more. In those rural areas, the residents did not have immediate access to a nearby hospital for treatment with emergency medical conditions.

In constrast, participating in Medicaid expansion yielded positive results for maintaining access and availability in some states (Gentili, Harati, & Serban, 2016). Additionally, there were increases seen in Medicaid drug prescriptions and primary care appointments in Medicaid expanding states (Tipirneni et al., 2015; Wen, Borders, & Druss, 2016). The increases do not indicate spending gains but a rise in health care service implementations. States that opted out of participating in Medicaid expansion experienced not only financial shortfalls but health care disparities due to decreases in cancer screenings and other preventative care (Choi et al., 2016). Overall, health care organizations and health care services in states that opted to participate in the Medicaid expansion provision of the Affordable Care Act prospered (Olsen, 2015).

There were also noticeable differences between health outcomes for low-income African Americans living in states that did not participate in Medicaid expansion. The states that did not participate in Medicaid expansion had deficient health outcomes and lacked access to adequate treatment for low-income African American residents (Shartzer, Long, & Anderson, 2016). Additionally, health outcomes and access were not optimal, and medical treatment was significantly lower for African-American adults in

states that did not participate in Medicaid expansion (Han, Nguyen, Drope, & Jemal, 2015). The state of Georgia experienced financial downfalls in medical services, consolidations of health care organizations, and closures of health care facilities (Reiter, Noles, & Pink, 2015).

There are benefits associated with having nearby access to a hospital such as limiting the cost to patients and hospital transfers. The financial cost associated with not having immediate access to a nearby hospital creates barriers with minority groups (Hanssens, Devisch, Janique, & Willems, 2016). Other barriers such as distance and cost are prevalent among elderly individuals living in rural areas seeking cancer treatment (Wills, Whitman, & English, 2017). When a hospital desires to transfer a patient to another hospital, it can be simpler when hospitals can collaborate (Evangelista, 2016). Although there are varying factors considered with patient transfers, nearby access is a considerable factor for optimal patient care (Feazel et al., 2015). If a resident in a rural town has medical care or procedures that require hospitalization farther from their residence, the hospital closures in their rural town would eliminate their ability to be transferred near their home. Therefore, I explored the experiences of 65 and older African-American residents of rural counties in Georgia after their nearby hospital closed.

Problem Statement

The research explored the experiences of 8 African Americans 65 and older residing in Stewart and Webster County after hospital closures near their residents. The participants encountered emergency medical condition treatment previously, and the research detailed their encounters. Due to limitations with emergency treatment options, this population detailed their experiences as it relates to receiving urgent care. The necessity of this study had two-fold implications. First, it allows those affected an opportunity to express their encounters concerning how hospital closures affect their lives. Secondly, it gives state and local officials some guided insight towards solutions for immediate medical treatment not only in the chosen rural areas where this research study was conducted but in other rural areas when hospital closures occur.

The positive social change significance of this research explores participant experiences encountered by the participants after rural hospital closures and suggest steps African Americans 65 and older in other rural towns prepare for when hospital closures occur. Moreover, this research can be helpful for the state, local, and federal agencies to procure alternatives for receiving immediate treatment for emergency medical conditions in similar rural towns after hospitals closures occur.

Study Purpose

In this study, I explored the lived experiences of eight African Americans 65 and older residing in the rural Georgia counties of Stewart and Webster who had been treated for a previous emergency medical condition. I explored their personal challenges and how they overcame them for receiving treatment with emergency medical conditions, their

communication with local health authorities concerning hospital closures and the alternatives for emergency medical condition treatment, and their family involvement with receiving treatment for emergency medical conditions.

The participants were interviewed to gather descriptions based on their personal experiences after hospital closures from 2013–2014. Their explanations helped determine how they were affected due to the loss of immediate access to a nearby hospital for treatment with an emergency medical condition. A hermeneutical phenomenological approach was used to guide this study, which was suitable because of the participants' age and the sensitive nature of their experiences (Høiseth, & Keitsch, 2015). Due to the possible personal experiences of the research participants, sensitively approaching yielded more openness.

Research Questions

The research questions were focused on investigating the experiences African Americans 65 and older living in Stewart and Webster County after hospital closures. The research questions helped provide details given by the participants. The research questions were focused on their concerns or thoughts as it relates to receiving immediate treatment for emergency medical conditions.

Research Question 1: What are the experiences with accessing immediate treatment for African Americans who are 65 and older living in Stewart and Webster County after the hospital closures?

Research Question 2: How did African Americans 65 and older living in Stewart and Webster County find other health care services after the nearby hospital's closure?

Conceptual Framework

The Andersen and Newman framework of health services utilization model is the construct that provided the framework for this study. The Andersen and Newman framework of health services utilization model is a conceptual framework typically used independently of other conceptual frameworks because it corresponds with identifying the predisposing and enabling factors (Babitsch, Gohl, & von Lengerke, 2012). The model describes three characteristics that form an individual's access to health services:

> I. Predisposing factors - The socio-cultural characteristics of individuals that exist before their illness. II. Enabling factors - The logistical aspects of obtaining care. III. Need factors - The most immediate cause of health service use, from functional and health problems that generate the need for health care services. (Levesque, Harris, & Russell, 2013, para. 6)

Using the model allowed access or demonstration of factors that led to the use of health services. The closure of the hospital that primarily served Stewart and Webster County residents removed local access to hospitals for treatment of emergency medical conditions. Thus, the framework was appropriate for exploring the conditions that either facilitated or impeded health service use for African-American residents 65 and older.

I also used the health belief model as an interpretive framework during data analysis (Jones, Jensen, Scherr, Brown, Christy, & Weaver, 2015). The health belief model allowed explorations into the participants' perceptions from the context of their indigenous/cultural environments and through the lens of their cultural beliefs and values. The model acknowledged the need to be sensitive to what the participants felt and said

was essential to them, including their attributions of meanings. In analyzing and interpreting the information given by the participants, there was also a need to stay aware of personal and cultural biases, local knowledge, and conceptual structures. Continual self-reflection and reflexivity on the analytical process and the obligation to observe personal processes helped in the illumination and reformulation of data (Wake, 2018). Chapter 2 will go more in-depth on the framework, which also included the life course chart and interactionism as a part of understanding the participants' experiences during data collection and analysis.

Nature of the Study

The study explores the participant's experiences based on their encounters after hospital closures occurred near their residents. The research is a qualitative phenomenological study, which explores the lived experiences of African Americans 65 years of age and older residing in Stewart and Webster County. The participants are residents treated for a previous emergency medical condition.

There were 8 participants chosen, 4 from each county interviewed. The descriptions of their encounters are based on individualized personal experiences after hospital closures occurred from 2013 – 2014. Their explanations showed how they were affected due to the loss of nearby access to a hospital for treatment with their emergency medical condition. The results of this study may also help define the health care disparities caused by these closures.

Definitions

Affordable Care Act: The comprehensive health care reform law enacted in March 2010, also known as ACA, PPACA, or "Obamacare" (Affordable Care Act, n.d.).

African American: "African American: an American of African and especially of black African descent (Afro-American, 2017).

Cohort: A group of individuals having a statistical factor (such as age or class membership) in common in a demographic study (Cohort, 2017).

Critical access hospitals: Rural community hospitals that receive cost-based reimbursement. To be designated a critical access hospital, a rural hospital must meet defined criteria that were outlined in the Conditions of Participation 42CFR485 and subsequent legislative refinements to the program through the BBRA, BIPA, the Medicare Modernization Act, the MIPPA, and the PPACA (Critical access hospital, 2017).

Disproportionate share hospital: Hospitals where the patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients eligible for both Medicare Part A and supplemental security income, and the percentage of total inpatient days attributable to patients eligible for Medicaid by not Medicare Part A. The disproprotionate share hospital patient percentage is defined as disproprotionate share hospital patient percent = (Medicare supplemental security income days/total medicare days) + (Medicaid, non-Medicare days/total patient days). The alternate special exception method is for large urban hospitals that can demonstrate that more than 30% of their total

net inpatient care revenues come from state and local governments for poor care (other than Medicare or Medicaid; Disproportionate Share Hospital, 2017).

Emergency medical condition: A condition with acute symptoms of severity (including severe pain) where the absence of immediate medical attention could result in placing the individual's health (or the health of an unborn child) in danger, impairment to bodily functions, or dysfunction of bodily organs (American College of Emergency Physicians, 2014, sec. 3).

Essences: Aspects or qualities of objects as intended. Describing phenomena and their essences is a common methodological goal in phenomenological research (Mil & Henman, 2016)

Ethnograph 5.0: A tool for facilitating analysis rather than a method in itself and therefore can feasibly be used to support a number of methodological or theoretical approaches. (Leung, 2015)

Health care administrator: A person who directs the operation of hospitals, health systems or other types of organization. They have responsibility for facilities, services, programs, staff, budgets, relations with other organizations and other management functions, depending on the type and size of the organization (Health care administrator, n.d.).

Health care praxis: A customary practice or conduct in health care (Sprague, Afifi, Ayala, & Musah, 2019).

Interactionism: A theory that derives social processes (conflict, competition, and cooperation) from human interaction (McLaughlin, 2017).

Life course chart: A heuristic device to study the interaction between individual lives and social change. It is a way of conceptualizing lives within the contexts of families, society and historical time (Kok, 2007).

Medicaid expansion: All states eligibility for Medicaid benefits vary, and all states must meet federal minimum requirements, but they had options for expanding Medicaid beyond the minimum federal guidelines (Affordable Care Act Medicaid Expansion, n.d.).

Rural: All population, housing, and territory not included within a specified urban area (Ratcliffe, Burd, & Alison, 2016). Rural hospitals are located near or in rural areas that provide essential access to inpatient, outpatient, and emergency medical services (EMS) for rural communities (Health resources and services, 2019).

Subjective lived experiences: The described experiences as a person lives them. It allows examination that is unique to the individual's lived situations and based on his or her reality, which is subjective. (Butler, 2016).

Assumptions of the Study

I made several assumptions during this study. First, I assumed that individual's act based on their beliefs about health care from living in rural communities, which can impede them from seeking alternative health care solutions available (Scott, Lyons, & MacPhail, 2015). Second, I assumed that communication, such as facial expressions, vocal changes, gestures, and hand movements are understood based on personal experiences (Perniss & Vigliocco, 2014). Third, I assumed that gaining an accurate interpretation of experiences is done through understanding the cultural, historical, and

social confines for an individual (Milbourne, & Kitchen, 2014). Fourth, I assumed that gender, ethnicity, and disability changed the influence of health care (Barrera, Castro, Strycker, & Toobert, 2013). Fifth, I assumed that individuals residing in rural areas had behaviors that influence personal factors and their social environment (Thomas, DiClemente, & Snell, 2013).

Scope and Delimitations

The research problem is the effect hospital closures have on African Americans 65 and older residing in rural towns. Their encounters detail experiences with issues or problems for receiving treatment for their emergency medical condition. The research shared their details and showed outcomes if a specific population is a more substantial portion of rural towns. The details were consequential when previous treatment for an emergency medical condition occurred. There are also other factors inclusive in the research, which are the effects hospital closures in rural towns have with this populations doctors, the admission processes and healthcare administrators involvement with creating a solution for this population.

A boundary associated with this research is sensitivity because of the research participant's age, race, and location. A research study likened to this has not occurred with the population chosen. The generalized information discovered through research concerning this population gives some indication that baby boomers are somewhat private; therefore obtaining the research participants could also be a boundary. Addressing all boundaries and implementing some measures are included in the research to circumvent the boundaries. The research is a phenomenological hermeneutical study

that used a framework that adequately integrated the life course paradigm and interactionism symbolically.

Utilizing the life course chart for this study helped explore the transitions encountered by 65 and older African Americans living in Stewart and Webster County. The life course paradigm also helped examine how these developments affected the participants over time after hospital closures occurred. The transitions will provide continued explorations of the effects caused by rural hospital closures for the participants.

Limitations

Although the research was prepared carefully, limitations were present. One limitation of this study was the sample size being too small. This sample might not represent the majority of African Americans 65 and older living in rural towns on an intermediate level. Another limitation is concerning the questionnaire I used for the interview processes. The interview questions were designed to measure the participants' encounters after hospital closures, but the interview process might not allow the participants to provide useful information about all they experienced (see Appendix A for interview questions). All interviews were transcribed for determining the accuracy of the data that were analyzed and with what degree of dependability.

Finally, phenomenological research limitations occur when participants and researchers cannot colloboratly relate to the research topic (Hepworth, Grunewald, & Walton, 2014). However, I guided participants during interviews if necessary so we stayed on topic.

Significance to Health Care Administrators

This study is associated with health care administrators and is designed to inform the health care praxis. Health care administrators as well as the community and government officials are important for providing stabilization to the U.S. health care system (Cronin, 2017). Health care administrators have employment in some rural areas and can be a primary stakeholder in the health care system. Their role in rural areas is not centralized to those served but broader to those who are necessary for services (Bhan et al., 2017).

Health care administrators in rural areas have encountered challenges associated with limited health care access while determining and implementing changes in the rural health care industry (Alhassan & Nketiah-amponsah, 2016). Nearby access to medical and other health care services can help foster better health-related outcomes (Karunanayake et al., 2015), but the absence of a nearby hospital and alternative treatment facilities for emergency medical conditions causes adverse outcomes for patients due to hospital closures in rural areas (Scuffham et al., 2016).

Health care administrators' problems are not only connected to access but also patient care, hospitalizations, and cost. Along with these issues, health care administrators have also encountered increases with workforce shortages and challenges recruiting and retaining qualified health care workers (Cassie, Moeckli, Cram, & Heather, 2017). Removing access to a nearby hospital has caused health care administrators to seek alternative accommodations for immediate treatment for emergency medical conditions (Porter, Haberling, & Hohman, 2016). For example, telemedicine has been

implemented by some administrators in hospitals located in rural areas (Potter et al., 2016). However, telemedicine is only usable when a hospital is nearby, and hospital closures eliminate this option in some rural areas. Health care administrators could also recommend monitoring devices as a solution to the lack of nearby access for receiving immediate treatment for emergency medical conditions. The use of monitoring devices alleviates discrepancies in physiological parameters from multiple patients, but this type of system does not identify methods or provide alternatives for help with immediate access issues (Lin, Labeau, & Vasilakos, 2015).

Health care administrators employed in rural areas have implemented health care alternatives that ensured health care needs were nearest to those communities (Ford, 2016). Health care administrators use their interconnectivity in rural areas along with legislators and other groups to explore methods that alleviate or address the impacts of lacking health care needs (Gittner, 2015). Overcoming the challenges in rural areas after hospital closures can include collaboration with residents, policymakers, researchers, and governmental officials. Discovering alternatives for hospital closures involves securing methods that provide access to replacement treatment methods and closer health care services (Ramamonjiarivelo et al., 2015).

Health care administrators that have addressed hospital closures before, during, and after obtained better results and discovered alternative solutions (Lail, Laird, McCall, Naretto, & York, 2016). Therefore, exploring the experiences of African Americans 65 and older after rural hospital closures could help health care administrators discover alternative solutions for losing nearby access to hospitals.

Summary

Chapter 1 provided some insights into African Americans 65 and older living in rural areas in Georgia when hospital closures occurred. The research questions were also presented to identify the objectives for the research. Chapter 1 also included discussion on the rural hospital closures in Georgia, a possible cause of the closures, and other human factors associated with these closures. Chapter 2 will describe the conceptual framework for this research study and the relevant literature.

Chapter 2: Literature Review

Introduction

The purpose of this study was to explore the experiences African Americans 65 and older after rural hospital closed, which could help provide information that can lead to solutions for emergency medical condition treatment in rural areas. The literature provides some outcomes related to disparities, which could be invaluable in understanding the experiences of African Americans 65 and older residing in rural areas. I reviewed literature on disparities in health care, race, and culture. Conducting a literature review provides an overview of literature related to the research topic (Davis, 2016). Reviewing literature that involves health care, race, and culture helped explore ways to address disparities for better equality (Truong, Gibbs, Paradies, & Priest, 2017).

The literature presented in this chapter will correlate with the experiences of African Americans 65 and older living in Stewart and Webster County after hospital closures. Chapter 2 provides a review of disparities in health care, race, and culture. The literature review was intended to provide empirical views aligned with the experiences encountered by the participants. For example, research has indicated a difference in the quality of life for senior citizens living in rural areas versus urban areas such as a reduced quality of life (Usha & Lalitha, 2016). Hospital closures in Stewart and Webster County caused a loss of immediate access to a nearby hospital for treatment of emergency medical conditions and affected African Americans 65 and older who are residents in Stewart and Webster County and have been treated for a previous emergency medical condition.

Literature Search Strategy

The research I conducted included a systematic literature search performed using ProQuest, PubMed, Ebsco, PLoS One, and the Walden University library. The literary search identified documents meeting specific inclusion criteria, including rural anomalies and demographics, health care, race, and culture disparities. The literature search also identified articles about health belief models, rural hospital closures, healthcare administration, health care administrators, and healthcare strategies. The literary search also identified documents related to the life course chart, interactionism, the loss of immediate access, nonfinancial barriers, Healthy People 2020 initiatives, and rural EMS assistance. All articles were published in English from 2012 to present. Since the research is at a doctoral level, it is usually standard to obtain documents less than 8 years old, plus any classic documents related to the literature review topic (Pati, & Lorusso, 2018). Since the original research began in 2012, the search went back to January 2012.

The documents included described a single study or were review articles, and aimed at healthcare and rural studies research. Articles were limited to those that included specific strategies for comprehending the effect on a particular population residing in rural areas with preexisting urgent medical needs. Excluded documents were those outside academic healthcare education, including continuing education for healthcare administrators, those concerning faculty knowledge and awareness. Excluded literature were news announcements, conference reports, or editorials on changes in healthcare treatment.

In total, 89 documents met the search criteria. I used a PRISMA flow diagram to show the results of the literature research (see Appendix D). Using the PRISMA flow diagram helped focus on reporting the reviews evaluating randomized trials, because it is an evidence-based set of items for reporting in systematic reviews and meta-analyses (Toews, 2017). Results were limited to articles concerning rural demographics, and other rural related information, which only yielded 5 articles, so the research was expanded to include other related research areas to expand available healthcare discussed in the four other literature articles.

There were 7 articles related to life course charts, 4 related to health belief models, and 12 related to interactionalism. Also, there were 4 articles related to the healthy people 2020 initiative, 4 related to the rural ems, 15 related to disparities, 16 related to rural disparities, and 13 related to cultural disparities.

Conceptual Framework

In this Chapter I provided a more in-depth view of the framework concerning the life course paradigm and interactionism as a part of understanding participants' experiences during data collection and analysis. I used this in addition to the health services utilization model described in Chapter 1. The Andersen and Newman framework of health services utilization model provided demonstration of the factors that led to the use of other health services for the participant's in this study. Also, the Andersen and Newman model identified factors that either facilitated or impeded seeking alternative access with treatment for the research participant's.

The life course chart is isolated and viewed as less noticeable as it relates to health outcomes (Lalanda, 2016). The life course chart was used to explore health-related issues and provides a view of the past, present, and future (Halfon, Larson, Lu, Tullis, & Russ, 2014). I used the life course chart to explore the transitions encountered by the participants and how these developments affected them over time after hospital closures. The life course paradigm is more suited for this research study when compared to demography where the choices of individuals are examined as a chain of causation (Glor, 2014). Although the participants' choices were part of their experiences, this study was focused on the effect of a hospital closure.

The life course chart also helped explore health care disparities and health care alternatives for African Americans 65 and older residing in rural towns (Cheng, & Solomon, 2014). The life course chart is consistent with phenomenological views and was efficient for studying the experiences of the participants (Skea, & Cert, 2016). The changing events created by hospital closures necessitated understanding their developmental processes and sociocultural meanings (Spaulding, 2015). The changing events occurred within the statistical, historical, and cultural context of African Americans 65 and older still residing in Stewart and Webster County.

The life course chart has also been used to show that adults who aged well had positive health and mobilization when connected to accessible health care treatment nearby (Black, Dobbs, & Young, 2012). The life course chart in this study incorporated four distinct areas that helped form a story for participants' experiences with a hospital

closure: (a) immediate access, (b) nonfinancial barriers, (c) the Healthy People 2020 initiatives, and (d) rural EMS.

As another part of the framework, I focused on guiding principles of symbolic interactionism. These principles suggest that people act based on the meaning of objects and events, and the meaning assigned can be centered on their interaction with other people. Additionally, people select objects and events out of their environment and process them through time to make meaning (Thomson, 2016). When the participants were asked about their experiences after a hospital closure, they were also encouraged to talk about their encounters. Each participant's story had a specific meaning because they processed the encounters over time, which indicated a story that offered details of what they experienced. Their interactions were interpreted and conveyed through their stories, which provided information about how the hospital closures affected them personally. The stories also provided information about how the participants chose to act during their experiences.

Another theory or construct that made up the conceptual framework for this study was the health belief model. The health belief model is a psychological model used to explain and predict health behaviors (MacArthur, 2017). The health belief model allowed for a linear, written format in explaining participant stories (Mou, Shin, & Cohen, 2016).

Literature Review Related to Key Concepts

Demographics of Participants' Location

Stewart County is a rural area in western Georgia with a population of around 6,058 (U.S. Census Bureau, 2015), with 2,868 being African American and 788 being 65

and older (Suburban stats, 2017). Webster County is also a rural area in western Georgia and has a population of around 2,799, with 185 African-American residents and 420 residents 65 and older (U.S. Census Bureau, 2015). The hospital that closed was a 25-bed critical access hospital that primarily served the local rural populations residing in these counties.

The hospital closure caused this population to lose immediate access to a nearby hospital for emergency medical condition treatment. Obtaining immediate alternative access to another nearby hospital for emergency medical conditions is determined by the geographical location of a town (Kelly, Hulme, Farragher, & Clarke, 2016). Due to the rural location of Stewart and Webster County, receiving emergency medical care is 40 minutes away or more.

Hospital Closures in Rural Areas

Lack of Access

Without immediate access to a hospital, there are limitations for nearby medical treatment alternatives, and an individual's health can deteriorate (Caldwell, Ford, Wallace, Wang, & Takahashi, 2016). Closer proximity or access to immediate treatment for emergency medical conditions is better for positive health outcomes for medical conditions and illnesses (Gautam, Hicks, Johnson, & Misha, 2013). Those living in rural areas with limitations for immediate access have faced health disparities (Daniels, & Auguste, 2013). The restrictions on nearby access create a need to travel further for medical treatment, which has led to ailments becoming worse (Bazzoli, Lee Hsieh, &

Mobley, 2012). Immediate access to a nearby hospital is also significant for patients undergoing end of life care (Waller, Dodd, Tattersall, Balakrishnan, & Fisher, 2017). Nearby access is beneficial when caring for patients experiencing medical conditions caused by life-threatening illnesses (Lynch, 2013).

African Americans 65 and older in Stewart and Webster County could relocate to a nearer to a hospital, but there is another preference to consider. Baby boomers prefer staying in one location and having more intimate surroundings for their security, strength, and comfortability (Yen & Anderson, 2012). Thus, the closure of rural hospitals increases insecurities and fear for residents (Mason, 2017). Additionally, losses with inpatient services as well as a lack of a nearby hospital caused patients to feel uncertain and unsafe (Walker, Clarke, Ryan, & Brown, 2011).

Patient safety is a necessity for prevention and treatment for medical emergencies (Soo-Hoon, Phan, Dorman, Weaver, & Pronovost, 2016) and includes ensuring the patient is stable enough for treatment (Sharfstein, Fontanarosa, & Bauchner, 2013), removing unknowns to offer medical treatment efficiently (Wachter, 2012). The objective of patient safety is helping a person feel safe throughout the treatment process and creating an atmosphere conducive to treatment (Carayon, 2016). Patient safety is compromised when there was a lack of immediate access to nearby hospitals ("When financially vulnerable," 2009).

Nonfinancial barriers. Nonfinancial obstacles encountered by African Americans 65 and older in rural communities after hospital closures are also relevant for this study. For examples, Kullgren, McLaughlin, Mitra, and Armstrong, (2012) concluded that

nonfinancial reasons occur more than financial for people not seeking medical treatment such as accessibility and accommodation. The perception of racism and racial discrimination is also a nonfinancial barrier (Allen, Call, Beebe, McAlpine, & Johnson, 2017). The perception of racism and racial discrimination exposes patients to delays or causes them not to seek alternative treatment for emergency medical conditions (Sorkin, Ngo-metzger, & De Alba, 2010).

Another nonfinancial barrier is the lack of shared information for alternative health care choices and providers. Information not shared with those who could be most affected by hospital closures or downsizing increases opposition (Barratt, Harrison, Fulop, & Raine, 2015). Though information could be shared using technological methods to help equip African Americans 65 and older, the lack of adequate technological sources can limit sharing information. Rural areas are more susceptible to having low service needs concerning the Internet and other technological aspects (Immonen, Vilko, Koivuniemi, & Laasonen, 2015). The necessary and appropriate technological skills should be available to ensure information sharing capabilities. The other nonfinancial barriers associated with hospital closures in rural areas were household expectations, cultural preferences, and attitudes and norms (Camillo, 2016). These and other nonfinancial issues could make it difficult to obtain essential access to optimal health care services for those living in rural areas.

Healthy people 2020 initiatives. The lack of access is the opposite of goals established by Healthy People 2020. The Healthy People initiative began with the Department of Health and Human Services in conjunction with the National Center for

Health Statistics (Office of Disease Prevention and Health, 2016). The objective of Healthy People 2020 includes diversity to aid in disease prevention and health promotion to improve the health, function, and quality of life for older adults (Fielding, & Kumanyika, 2009).

The health objectives of Healthy People 2020 are not just focused on public health issues but also ensuring measures to solve public health issues (Shi & Johnson, 2014). For example, there are goals that help address the needs associated with access and patient safety, which can help determine measures to implement prevention and treatment processes. The four primary goals of Healthy People 2020 are interconnected (National Center for Health Statistics, 2011) and are outlined to help Healthy People 2020 obtain relevant data to address health services objectives (Bryant, Hess, & Bowen, 2015). Healthy People 2020 also address the lack of nearby access for immediate treatment of emergency medical conditions with their guidelines:

> AHS-6.2: Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care.
>
> AHS-8 (Developmental): Increase the proportion of persons who have access to rapidly responding prehospital EMS.
>
> (National Center for Health, 2011).

Using AHS-6.2 and AHS-8 (Developmental) could help recognize and improve access related issues. For example, the lack of direct access to a nearby hospital for African Americans 65 and older in Stewart and Webster County after a hospital closure. The Implementing the AHS-6.2 and AHS-8 (Developmental) objectives could provide direct

solutions for immediate access for African Americans 65 and older living in Stewart and Webster County.

Rural emergency medical services. EMS transport units provide an alternate source of immediate treatment for medical conditions. Citizens living in rural towns utilize EMS transport vehicles on a higher scale when compared to the national use in the United States (Wang et al., 2013). The EMS transport vehicles are alternatives but may not provide adequate nearby access. Sufficient nearby access for treatment of emergency medical conditions is important for the survival of citizens living in rural areas (Federal Office of Rural Health Policy, 2019). Providing EMS transport to residents living in rural areas is also challenge (Chanta, Mayorga, & McLay, 2014). The problems are not having enough volunteers, other staffing needs, and transport availability (Pennel, Tamayo, Wells, & Sunbury, 2016). Limited staff and mobile transport units can be a factor when multiple medical emergencies occur at the same time. These challenges could cause a lack of covering some medical emergencies in rural areas.

A lack in EMS can create vulnerabilities with receiving immediate treatment for emergency medical conditions. There was not a contingency plan or emergency system design for emergency medical service coverage plans in Stewart and Webster County to. The contingency plan or emergency system design may have alleviated the increased patient medical needs due to hospital closures. Immediate emergency system design alternatives that address increased needs for receiving treatment with emergency medical conditions ease citizen concerns (Lee, 2014). When there are limitations with EMS vehicles, the results could lead to death (Lu & Davidson, 2017). Without an improved

system in place, the local EMS transport units in Stewart and Webster County are not viable alternatives for nearby access to immediate treatment for emergency medical conditions.

Disparities in Health care

In the United States, health care disparities are higher among individuals who are 65 and older and with a lower socioeconomic status ("U.S. health care," 2016). Health disparities occurring within ethnic groups and minorities are increasing, although measures are in place to eliminate them (Fiscella & Sanders, 2016). Health disparities are also rising within the elderly population due to issues associated with not having adequate health care access (Du & Xu, 2016). Health care disparities are also higher in communities with more significant populations of African Americans, those in lower classes, or lacking quality access to health care treatment (Nelson, 2016).

Further, the separation of income margin between those living in rural and urban areas becomes more noticeable each year (Dickman, Himmelstein, & Woolhandler, 2017), which can create health care inequalities and adverse treatment outcomes for residents in rural areas. Lessoning the gap in health care inequalities includes optimal health care alternatives and closer medical treatment facilities (Evandrou, Falkingham, Feng, & Vlachantoni, 2016).

Health care disparities are connected to low-income status and the lack of finances for traveling distances for other medical treatment (Flora, Flora, & Gasteyer, 2015). Improving health outcomes related to health care disparities includes having closer access to adequate medical treatment facilities (McLaren, Ardington, & Leibbrandt,

2014). Addressing the issues associated with having closer access helps explore measures that can be used to prevent health inequalities with specific ethnic groups such as African Americans (Purnell et al., 2016). Health care disparities are also environmentally related, because residents living in specific environments such as rural areas usually receive health care treatment nearer to their living environment (Padilla, Kihal-Talantikit, Perez, & Deguen, 2016). Optimal and positive health care outcomes are better when using treatment facilities closer to the environments people reside in (Rubin, 2015)

VanderWielen et al. (2015) advocated for provisions of free clinics in rural areas where health care disparities were prevalent. Their research suggests addressing the health care disparities to help solve the health problems in remote and isolated areas. Addressing health care inequalities in rural areas is a non-negotiable factor in securing solutions for health care disparities (Cai, Coyte, & Zhao, 2017). When seeking answers for the increase of inequalities in health care, exploring who is affected the most and how they are affected provides guided solutions for disparities in health care (Betancourt, Corbett, & Bondaryk, 2014). Thomas (2014) concluded that health care disparities were increasing among minority groups, to include Pacific Islanders, African Americans, and Latinos. The increases seen in minorities, such as African Americans as compared to other races could cause positive health outcomes to decrease significantly.

Resolving disparities in health care for rural areas does not only include addressing access issues, but also quality and safety issues (Lynch, 2017). Addressing quality, patient safety and having nearby access involve communicating about the absence of a nearby hospital to treat emergency medical conditions. The communications

among local and federal agencies, as well as the residents in rural areas, could provide some results for closing the gap with disparities seen in health care systems in rural areas.

Racial Disparities.

Nelson (2016) concluded that race is contributing to health care disparities seen among African Americans. Racial disparities caused by perceived institutionalized racism and discrimination is also prevalent amongst African Americans (King & Redwood, 2016). In comparison to other ethnic groups, African Americans were disproportionally ranked higher for having health care disparities (Jackson, & Gracia, 2014). Georgia's rural hospitals cared for more minorities, low-income individuals and the uninsured in comparison to all other races of people (Bastain, Garner, Barron, Akowuah & Mase, 2016). When health centers, such as hospitals are located nearer to rural communities and provided closer access, there was a decrease in racial disparities (Seymour, Polsky, Brown, Barbu, & Grande, 2017).

The National Health care Quality and Disparities Reports stated, "Racial and ethnic disparities result from complex interactions between patient factors related to social disadvantage, clinicians, and organizational and health care system factors" (Fiscella, & Sanders, 2016, p4). When hospital closures occur in areas comprised of more African Americans than other races, interactions are limited or absent, causing an increase in racial disparities (Manuel, 2017). When racial disparities are present in health care, there are substantial losses economically, and there are increases in premature deaths (LaVeist, Gaskin, & Richard, 2011). Racial disparities affect mortality rates and have a financial effect on minority groups (Chin, 2015).

African Americans 65 and older living in Stewart and Webster County encountered health care treatment inequalities after hospital closures occurred (Andrews, 2014). African Americans 65 and older living in other rural areas in Georgia were also left disadvantaged for receiving immediate medical attention and medical supplies (Caldwell, Ford, Wallace, Wang, & Takahashi, 2016). Ayanian (2015) stated, "Racial disparities in life expectancy are a key indicator of inequity in health outcomes" (p. 1). Racial disparities due to hospital closures in rural areas have a determinate outcome rooted in segregation (Zhang et al., 2017). Unintentional discrimination is a significant driver for health care inequalities seen in rural towns (White, Haas, & Williams, 2012).

Unintentional segregation creates a stigma for minorities living in specific areas who cannot obtain optimal immediate health care access (Zarsky, 2014). African Americans 65 and older living in Stewart and Webster County classified as socially disadvantaged could be classified with this stigma. This stigma is a primary driver for the causes of mortality and morbidity amongst people 65 and older (Hatzenbuehler, Phelan, & Link, 2013). Inequalities in health care which occur within specific sexes, races/ethnicities, and those with lower socioeconomic status cause health care disparities (Kistin, 2015). Health care disparities occurred and afterward were a cause for Georgia policymakers to address inequalities. Addressing inequalities before may have decreased racial disparities in Georgia's rural areas. Hatzenbuehler et al. (2013) stated,

> Fundamental cause theory proposes that some social factors or circumstances remain persistently associated with health inequalities over time despite dramatic

> changes in diseases, risk factors, and health interventions. Inequality persists because fundamental causes have certain characteristics. (para. 4).

Exploring and closing the research gaps has implications for advancing and strengthening the literature for effective interventions and policy-based solutions. Focusing on a change to help eliminate health care inequalities occurring within minority groups would result in closing the gaps associated with racial disparities (Bleich, Jarlenski, Bell, & LaVeist, 2012).

Cultural disparities. Understanding an individual's cultural beliefs helps provide them with adequate health care treatment (Hadziabdic, Lundin, & Hjelm, 2015). A part of cultural competency centers on having access to nearby medical treatment (Haynes, 2016). Established cultural beliefs help with transitioning and reaching diverse cultures, but also understanding cultural disparities (Speck, 2016). African Americans 65 and older are baby boomers that compose more than half of the population in Georgia's rural areas (U.S. Census Bureau, 2015a). Baby boomers desire urgent care locally and are accustomed to receiving critical care treatment locally (Gelber, Grünebaum, & Chervenak, 2016). The Office of Policy Development and Research (2013) stated, "Most seniors indicated they would prefer to age in place, either staying in their current home or choosing from a range of affordable, age-appropriate housing options within their community" (para. 2).

Exploring the lifestyle design of baby boomers is essential for harnessing the type of health care they will readily utilize or reject (Lee, Zegras, & Ben-Joseph, 2013). African Americans 65 and older living in Stewart and Webster County encountered

limited alternatives for urgent care treatment. Their choices include relocating, traveling or seeking EMS for treatment with emergency medical conditions. In comparison to other generations, baby boomers are more connected to their local environments and their individualized preferences (Siren, & Haustein, 2013). Therefore, choosing alternative treatments for emergency medical condition farther from their resident contradict the ideals of baby boomers. The contradictions can have measurable effects for African Americans 65 and older residing in Stewart and Webster County.

Health care, racial and cultural disparities for African Americans 65 years of age and older could be imminent as a result of hospital closures in Stewart and Webster County. The disparities were not only based on the lack of a nearby hospital for emergency medical condition treatment. Due to the hospital closing that served Stewart and Webster County, there was also a lack of providing stabilization treatment. Rural hospitals initially help stabilize patients experiencing urgent medical conditions. Once stabilized, the patient is transitioned to another hospital better equipped to handle the patients' medical situation (Lipsky, & Glasser, 2011).

Critical access hospitals provide critical care access in rural areas and ensured essential care was accessible and closer to rural communities (Casey, Moscovice, Holmes, Pink, & Hung, 2015). The hospital that served Stewart and Webster County was a critical access hospital. The closure of this hospital caused African Americans 65 and older to encounter an essential loss of access for receiving immediate treatment with emergency medical conditions (Natafgi, Baloh, Weigel, Ullrich, & Ward, 2016).

Health care, racial and cultural disparities affect patient health when medical treatment available is limited or absent (Marquand, & York, 2016). When urgent medical treatment is lacking or inadequate locally, finding treatment alternatives could lead to death. The likelihood of mortality increased when seeking immediate treatment for an emergency medical condition (Hsia et al., 2014). Joynt, Chatterjee, Orav, and Jha (2015) discovered from 2003 – 2011 there were no increases in some rural area hospitalizations and mortality rates due to hospital closures. These statistics changed in 2014 because in some rural areas there was an increase in mortality rates as a result of limited access to urgent and immediate medical treatment (James, 2014).

Summary

Chapter 2 discussed health care, racial and cultural disparities that could occur due to hospital closing which primarily served the residents of Stewart and Webster County. After the hospital closure occurred, there was not any immediate access to a nearby hospital for receiving treatment with emergency medical conditions. Chapter 2 discussed the individual perception of having access nearby which is not based solely on medical needs, but immediate access for those affected more than others. Considering this is a reason for exploring the experiences African Americans 65 and older encountered in Stewart and Webster County after the hospital closures occurred.

The experiences encountered by the participants are related to the loss of a nearby hospital for treatment of emergency medical conditions. The participants encountered this obstacle and a lack of alternative medical treatment remedies. Their experiences were also related to the absence of immediate communication addressing the absence of access to receiving immediate treatment with emergency medical conditions. The other alternatives created and implemented by Governor Deal were networks of regional hospitals, Wi-Fi-equipped ambulances, community health centers and school clinics (Robeznieks, 2014).

Governor Deal's methods were viable, but not feasible for receiving immediate treatment for emergency medical conditions nearby. The participants encountered health service treatment limitations, such as EMS availability. Due to the hospital closure which served Stewart and Webster County, there may be some measurable effects on the

research participants. The quantifiable impacts correspond with receiving emergency medical treatment regardless of the costs and time associated with nearby treatment.

Chapter 3: Research Methodology

Introduction

This qualitative study provided a better understanding of the effects of hospital closures on the experiences of African Americans 65 and older in Stewart and Webster County who were treated for previous emergency medical conditions. Qualitative research is better when the researcher knows little or nothing about the research topic (Stichler, 2016), and it includes gathering data and documenting the data (Malagon-Maldonado, 2014). There are also different data collecting methods used in qualitative research such as observing and interviewing the participants or engaging in case studies of the participants (Martin, 2015). In this study, I used interviews to explore the experiences of participants. Conducting interviews allows for insights into participants' feelings and information from their behavior and facts (Snelgrove, 2014).

Chapter 3 will provide details about the research methodology and the process of the study. Chapter 3 will also provide details about the data collection and qualitative analysis, the issues with trustworthiness, the participant selection strategies, and the sample selection. Additional information aligned with the research objectives will conclude Chapter 3.

Research Design and Methodology

I explored the personal experiences of African Americans 65 and older residing in Stewart and Webster County related to hospital closures that occurred in the towns where they reside. Utilizing these participants ensured the data was primary, not secondary. Primary data allowed the information to be retrieved directly from the participants and to

be done in the actual location which is feasible for both quantitative and qualitative studies (Castleberry, & Nolen, 2018). The participants were chosen based on being treated for an emergency medical condition previously. The research questions helped explores what the experiences were for African Americans 65 and older in Stewart and Webster County after hospital closures.

I employed a qualitative phenomenological research design to help answer the research questions, which allowed me to use interviews, field notes, a life course chart, and demographic information. The methodology guiding the phenomenological approach was hermeneutic phenomenology. Hermeneutics is a philosophical base for research methodology (Diehm, 2015). The focus of hermeneutic phenomenology is the experience of individuals and groups (Oxley, 2015). Hermeneutic phenomenology allows researchers to learn about the experiences as expressed openly by the participants (Henry, Rivera, & Faithful, 2015; Miles, Chapman, & Francis, 2015). A hermeneutic phenomenological approach provides descriptions of experiences from participants' viewpoint of an event (Koopman, 2015), because the approach stresses that only those who have experienced the phenomenon can communicate the experiences to the outside world (Matua & Van, 2015).

Using the hermeneutic phenomenological approach with this research helped explore the lived experiences of a racial population (see Bazzul, 2015). The interpretations related to hermeneutic phenomenology are descriptive of the interpretive process (Milbourn, McNamara, & Buchanan, 2015). Using hermeneutic phenomenology generates the best explanation of the research phenomenon (Van Manen, 2015), as it

emphasizes participants' subjective experiences and interpretations of the phenomena (Finlay, 2012). In this study, participants detailed their experiences related to the phenomenon of hospital closures through interviews.

Another approach I considered for this study was a narrative design. Narrative and phenomenological research methodologies can be socially constructed, and there is overlap. However, narrative analysis is focused on how the participants tell their stories, whereas hermeneutic phenomenology is about the expressed content (Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Further, unlike the narrative approach, the hermeneutic phenomenological approach includes the researcher's involvement with the experiences. The researcher can see and feel the expressions of the participants. In this study, obtaining a closer view of the participants lived experiences provided conciseness for the research outcome.

Hermeneutic phenomenology is consistent with the overall design of this study, and it has been used with other life course studies (Lalanda, 2016). A natural tool that can be useful in the life course chart is hermeneutic phenomenology because the descriptions associated with life course are essentially phenomenological. The descriptions serve as the lived experience, which allows meaning to be interpreted from the analysis of the life course placed into a text format (Skea, 2015). Using hermeneutic phenomenology in this manner allows the lived experiences of the research participants, as it relates to the specific phenomenon, to emerge from their stories (Wilson, 2015).

The participants may have shared life experiences and shared essences, and the relationships between them can emerge from their individualized experiences. Thus, I

used interviews that were designed to draw out stories of the changes associated with the participants' experiences. Because phenomenological research involves participants' lived experience, it is important to help guide the participant so he or she stays within the parameters of the research topic (Woith, Jenkins, Astroth, & Kennedy, 2014). The research methods I chose helped explore how the participants adjusted to hospital closures. For instance, the four elements of the life course chart were used to bring shape to this research study, which was consistent with hermeneutic phenomenology's emphasis for understanding culturally and historically situated horizons shared by a group (Daher, Carré, Jaramillo, Olivares, & Tomicic, 2017).

Considering the participants experiences, along with their extrinsic relationships, interactions, and sociocultural and historical beliefs were relevant for the interviews. I also wrote field notes to help detail stories about the life course for each participant. Analyzing participants' individual stories was done to understand how the research participants' roles, events, and sociocultural meanings changed after hospital closures. The stories showed how the participants adjusted to hospital closures, but themes related to the influences associated with the participants' changes within the statistical, historical, and cultural contexts did not emerge as the stories were analyzed.

Hermeneutic analysis comprises cyclical interpretations of the participants' experiences as part of the hermeneutic cycle (Sampoornam, 2015). Hermeneutic analysis incorporates recording the communication that occurs during the interview process as an initial step (Heinonen, 2015). After completing the interviews and transcribing the field notes, data checking for accuracy was done by listening and comparing the transcribed

notes and the recordings. Completing the data merging process into an Ethnograph 5.0 was accomplished for qualitative data analysis.

I also transcribed audiotapes. Transcribed notes and collected demographics were always kept in a locked cabinet except when analysis was needed. Using hermeneutic analysis included permanently recording written notes as the first step for keeping the verbal and nonverbal communication of the interview process (Sloan & Bowe, 2015). This process allowed what was recorded to become the working ground for the study and to provide a socially constructed meaning. Permanently recording data also allows for a working field, which provides an understanding of the data that is beyond logical analysis (Burgin, de Vey Mestdagh, 2015).

Hermeneutic interpretation is also possible when transcribing the data to give meaning to readers. Therefore, this interpretation involves more than a nonintentional group of words (Muganga, 2015; Nielsen & Angel, 2016). Hermeneutic interpretation is a combination of knowledge that comes from thinking something through and relating it to plausible sense allowing researchers to situate the text within culture and history (Jørgensen, 2015).

During analysis of the data, it was important to bracket the information based on personal encounters and experiences. When bracketing, researchers should avoid biases, assumptions, preconceptions, and prejudices. After bracketing, answering the aims of this research study was accomplished through thematic analysis. The thematic analysis was conducted in a nonlinear fashion and was useful for focusing on examining the themes

within data (Percy, Kostere, & Kostere, 2015). The following steps guided the thematic analysis:

- Grouping the interview sections according to the county where conducting the interviews.
- (There were 8 different 65 and older African Americans interviewed in Stewart and Webster County, 4 from each county.)
- Using specified coding that corresponded with the experiences given by the participants. The coding was done through labels as it related to personal experiences and timing of the hospital closures.
- Placing each area of the paradigm together for further analysis and making determinations for relational purposes.
- Choosing and connecting exemplary themes, which was done throughout the life course to complete the story and diagnose the changes in each encounter.

Exploring the individual experiences and how they affected each participant built the outcome of this study. Conducting interviews with the 8 participants helped with gathering their descriptions and the meanings of the central themes in their life related to hospital closures. Answering the interview questions was pertinent to resolving the research questions.

Symbolic interactionism and the life course chart helped guide the interviews and produced an analysis. The life course review chart served as a tool that helped the participants' remembers their experiences before the interview. The chart is a way of obtaining life course information because it allows an appraisal of the social and

historical context by the researcher as well as the participant (Van Regenmortel et al., 2016). The chart was sent before the study and reviewed with the participant at the first interview session. The participant and I completed and discussed the chart together in the first interview if the participants did not complete it. Analyzing the chart as a part of the data using hermeneutic phenomenology was part of this study (see Appendix B for a sample of the life course review chart).

Participant selection strategy. The participants for this study were African Americans 65 and older living in Stewart and Webster County who were treated for a previous emergency medical condition. Their lived experiences helped to explore their emotions and what they encountered after hospital closures. The encounters were examined based on limitations for treatment of emergency medical conditions at a nearby hospital. Investigating participants' experiences helped determine the effects of the hospital closures on the participants' lives. There were 8 participants consisting of 4 males and 4 females chosen from each county.

The participants were recruited by submitting a request form and providing information about the study to doctor offices, human services organizations, and religious and civic organizations. Potential participants could have voluntarily contacted me for more information if desired or had interest in participating in the study. I fully explained the purpose of the research to those interested in participating. There was an initial screening interview conducted over the telephone with potential participants. Once the participants met the criteria based on the phone interview, an initial assessment session occurred.

Permission from the participants to conduct the interviews was granted in person by the participants. Each research participant consented to conduct the interviews in their homes. The interview process included observing participants' reactions, responses, and actions during the interview process. The observations and interview process were conducted carefully and in the least intrusive way in the interview environments.

Observing the participants ensured direct visual interaction with research participants. The visual interaction included watching facial expressions, hand gestures, and subtle movements that correspond to verbal communication (Takyi, 2015). Focusing on the participants' responses and not using a specified observation technique was part of the interview process.

The interviews were intended for 20 minutes, but there was flexibility for engaging in natural conversations. The use of interviews in qualitative research is practical when trying to obtain the participants perspective or emic concerning an outlined issue (Bevan, 2014). Using interview questions that were open-ended encouraged input from the research participants (Englander, 2012). The interview approach is standard because it allows the researcher to hear and see the participants' emotions (Gray, 2013).

The interview process was well-structured and in an environment conducive to engaging with the participants. Conducting interviews in a proper environment and using well-structured formats promotes consistency in the investigative processes, which invoke responses from the research participants (Converse, 2012) Using a phenomenological approach in the interview process also allowed a method that results in

offering labels and different descriptions for research outcomes (Dowling, & Cooney, 2012). The interviews were conducted by printing the interview questions on a piece of paper and using multiple copies. Before the interviews began, the participants had a copy of the research questions. A video camera was also used to record the interviews, and I handwrote notes.

The use of written notes allowed the questions to be extended or helped to investigate further. Before taking handwritten notes, there was a dialogue between me and the participants for permission, understanding, and clarity of their use. Moreover, because the social, historical and cultural experiences of women can be different than for men, the unique experiences of each gender was studied independently and not combined into one analysis that neglects the unique experience of any gender.

There were no significant risks anticipated for the participants. Reducing inconveniences is accomplished by allowing the participants to arrange a time and place for the interviews (Gentles, Charles, Nicholas, Ploeg, & McKibbon, 2016). The participants could also have terminated the interview at any time. The participants could have rescheduled or dropped from the research study without explanation. Informing each participant of their right to refuse to answer any question and talk about any topic or end the interview whenever they desired was done before and during the interviews. If research participants became fatigued or overwhelmed during the interview process, the interview would have ended. There were no invasive procedures included in this study. There were no other alternative procedures for lesser risk than the interview format.

Maintaining confidentiality for all participants was done by changing their names to pseudonyms. The pseudonyms were usable in all written records. Only I have access to the actual names, addresses, and phone numbers of the participants. These will remain in a locked cabinet in the mentor's research office and destroyed 5 years after completion of the data analysis. Participants received no monetary reward for participation in the study. There was no perception presented of any coercion to participate in this study for the participants. Further, I have experience assessing the health of people with severe physical impairments and would be able to determine if the participants were becoming compromised during an interview. If the participants began to show any signs or symptoms of medical distress, I would have used the local 911 system for advanced care. In sum, the risk/benefit ratio for this study was favorable.

The sample selection. Using probability sampling was more appropriate for this study in comparison to nonprobability sampling. A probability sampling assumes the population is spoken for and utilized in its entirety (Kline, 2017). Using a probability sample allows errors to become closer estimated when compared to nonprobability sampling (Setia, 2016). Nonprobability sampling is not conducive for this study because it would have provided too much room for errors to occur in the study (Moy & Murphy, 2016). The problems were indicative of not having an adequate sample of the research population.

Convenience sampling was also not relative to this study because it involves using those who are conveniently available, and participants in this study were interviewed based on their schedule (Acharya, Prakash, Saxena, & Nigam, 2013). A purposeful

sampling also did not seem accurate for this study. A purposeful sampling occurs when a researcher uses subjective analysis, and this study required objectivity for the study outcome (Robinson, 2014).

The accurate number of participants for this study provided data specifics for the research. Establishing and using the appropriate sample size for this study was relevant to understand the effects of the research problem (Malone, Nicholl, & Coyne, 2016). A quality sample size is large enough to provide relative data but small enough to keep the data practical and straightforward (Das, Mitra, & Mandal, 2016). Obtaining a sample size for interviews in research studies included exploring population differences, such as mobility religious beliefs family values, and communication barriers (Perneger, Courvoisier, Hudelson, & Gayet-ageron, 2015).

A sample size that was accurate enough to represent the targeted population gives strength and validity to the research (Beck, 2013). The representative sample is utilized in research because it is conducive to obtaining a valid research outcome (Nelson, Wooditch, & Dario, 2015). The representative sampling method allows the researcher to select participants based on subjective judgment, rather than random selection (Mullinix, Leeper, Druckman, & Freese, 2015). The sample size for this research was a probability sample and included aspects and outcomes of the researched population (Robson, & McCartan, 2016).

Data Collection Method and Qualitative Analysis

The participant selection strategies included the sample selection, sample size, recruitment, and human subject protection. Outlining each in detail is in the following

sections. Using quality data collection methods is a choice for obtaining necessary data, as opposed to numeral values (Gelling, 2015). Researchers using quality data collection methods understand the participant's experiences in real time through personal interviews (Colorafi & Evans, 2016). Insights are not channeled through graphs and statistical tables but evolve as researcher's interview actual participants. Specifically, interviews will be used to retrieve the data for this study. Drawing out the participants experiences after the closure of rural hospitals included designed interviews for that purpose.

Choosing an adequate sample size for the interview process is vital for research. (Kadam & Bhalerao, 2010). Choosing a size too small or too large could yield offsetting results, therefore choosing less in number but adequate to represent the population could be sufficient. Using a simple equation could help determine a sample confidently knowing there is a high probability that this study is statistically accurate with the correct sample size. Establishing an adequate number of participants provides a generalized and focused purpose without gathering additional and unnecessary information (Hazra, & Gogtay, 2016). In Stewart County, there were 939.65 African Americans 65 and older (U.S. Census Bureau, 2015). When using a confidence level of 95%, the population size of 939.65, and a margin of error of 5%, the ideal sample size would be 273, which is too large.

In Webster County, there were 588.73 African Americans 65 and older (U.S. Census Bureau, 2015). When using a confidence level of 95%, the population size of 588.73, and a margin of error of 5%, the ideal sample size would be 233, which is too large. This research will utilize 8 African Americans participants, 65 and older. Choosing

8 research participants was determined based on the total population size, the margin of error, confidence level and standard of deviation (Solon, Haider, & Wooldridge, 2015). Four research participants in Stewart County and 4 in Webster County will be interviewed, inclusive of 2 men and 2 women from each county.

Using positivism as the orientation for this qualitative study is not warranted; therefore, using a sample size of 8 provides research outcomes relevant for understanding the chosen population (Boddy, 2016). All data were collected with explicit permission from the participants and in full compliance with the Institutional Review Board (IRB) guidelines. Collecting and using the data was taken to construct outcomes for the research plan. The data collected was obtained through interviews and observations with the participants. Interview questions were open-ended and engaged the most input from the participants using hermeneutic phenomenology. The interviews were individualized to explore differences or similarities with the participant's experiences.

Family relationships, human service agencies, along with statistical, historical and sociocultural periods helped explore individualized experiences. The interview process goal was to elicit responses which detailed the encounters experienced by the participants. The details were analyzed to depict the type of experience encountered after hospital closures occurred as it related to treatment for emergency medical conditions.

Issues with Trustworthiness

In addition to the importance of elicitation mentioned above, when participants are always directly accessible, data analysis will inevitably be based on inference (Dixon-Woods, Kocman, Brewster, Willars, Laurie, & Tarrant, 2017). The participant's

responses for this proposed study were used to garner the inferences. As a result, the research design included measures to ensure the trustworthiness of the research results. Data triangulation was made possible through multiple data sources. Maintaining ongoing contact with the participants throughout the process of data collection and obtaining consent to stay in touch with them concerning the findings of the study occurred.

Ensuring the quality of the data and transcribing the data for later use was done by recording the interviews. Recording the interviews with the direct permission of the participants was accomplished through the usage of a video camera. Using this type of recording device was for dependability and confirmability. Using consent forms that were IRB approved ensured fairness and capability. The consent form provided validation from the participants' for recording what was intended and outlined as part of the study. The critical aspect of verification and validity of the information observed and transcribed was member checking (Baillie, 2015). Member checking was ongoing and coincided with the semi-structured interviews and informal conversations with the research participants. Member checking was used to check and critique the collected data.

The use of member checking ensures accuracy, fairness, and credibility (Birt, Scott, Cavers, Campbell, & Walter, 2016). Member checking also ensures the data quality for further investigation (Ang, Embi, & Yunus, 2016). Member checking also creates a system of triangulation, which allows research participants to triangulate what the researcher observed and how the researcher interpreted what was seen (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). The process of triangulation allows

the researcher to review the researched material for accuracy, palatability, and correctness (Fusch & Ness, 2015).

The interpretive nature of this dissertation formulates in qualitative research design. Qualitative research helps detect the needed audience and drive for referencing the identified research problem (Alase, 2017). Using qualitative research affords varying differences regarding data collection methods in comparison to quantitative research methods (Monette, Sullivan, & DeJong, 2013). Qualitative research gives the researcher a guide that affords a clear result not a predictive result for the research (Halcomb & Hickman, 2015). The qualitative research design offers research opportunities for explorations with a natural course of interaction. These opportunities advocate an open and honest forum for discussion and discoveries. The qualitative research design is beneficial in answering the research questions and is more efficient based on participant based research.

Elo et al. (2014) stated, "The trustworthiness of qualitative content analysis is often presented by using terms such as credibility, dependability, conformability, transferability, and authenticity" (para. 1). These guiding principles of qualitative research design helped maintain the research goals. Keeping these guiding tenets also helps avoid weak analysis, biases, interpretations that are shallow, mismanagement of data, disorganization or irrelevance, and tangent traps (Stichler, 2016).

The Need for a Pilot Study

Pilot studies are similar but smaller than the actual research study and pilot studies prepare researchers for their study (Eldridge, Bond, Campbell, Hopewell,

Thabane, Lancaster, & Coleman, 2015). Using 10 – 20% of the sample size chosen for the actual study is a significant sample size for a pilot study (Viechtbauer et al., 2015). Although this is a low number in comparison to the actual study, it would be useful for deciding if the primary study is formable. The pilot study also helps with the appropriate framing of time, determining the viability of the interview questions and analyzing the cost and study methods (Carey, Haviland, Tai, Vanags, & Mansell, 2016).

Using a pilot study also advocated a research strategy that includes addressing logistical issues that include checking the instructions for comprehension, checking the wording of surveys and checking the reliability and viability of results (Wray, Archibong, & Walton, 2017). A pilot study is also useful for determining if the final questionnaire is constructed to yield the needed information (Alami, 2015). Pilot studies are utilized to help avoid misleading, inappropriate, or irrelevant questions with surveys and consistency is seen with research instruments (Cook, Beard, Cook, & MacLennan, 2016). Electronically administering pilot studies was acceptable, but the pilot study was conducted personally and individually with the participants (Schulz, Zoller, Nickels, Beutel, Blettner, Wild, & Binder, 2017). Obtaining and utilizing the participants for the pilot study followed the same guidelines for obtaining participants for the actual study.

The pilot study's design has an emphasis on providing information about the research process and the likely outcomes (Thabane & Lancaster, 2017). The findings of the pilot study are reported in detail and consist of 6African Americans 65 and older, residing in other rural areas in Georgia after hospital closures occurred. There were 2 participants chosen from Folkston, Georgia; Jenkins County, Georgia; and Ellijay,

Georgia, which are different rural towns than where the proposed research study was. There were 3 women and 3 men chosen for the pilot study. Participant selection followed the same criteria and guidelines as outlined in the actual proposal.

Chapter 4 of this study details the improvements made, if necessary to the actual research design and the research process as a result of the pilot findings. The results of the pilot study also included research protocols, whether the proposed methods or instruments were inappropriate or complicated, and warnings regarding the weaknesses in the actual research study. Furthermore, the pilot study showed if there are any ambiguities and if the research participants had any difficulty with responding.

The responses of the participants in the pilot study were analyzed to discover if there were failures to answer questions, if they gave several answers to the same question, and may include written comments in the margin concerning the research participant's responses. The findings present the outcomes and observances of the pilot study, along with the recommendations and changes warranted for the actual research study. The pilot study was done to examine the data collection instruments used for the primary data collection.

Also, the pilot study provided a trial run under realistic conditions. The pilot study further allowed getting as much information as possible concerning the interpretation of the research questions. In addition to comparing the objectives for the actual study, the pilot study was useful towards understanding how to improve data-collecting routines, and checking the appropriateness of standard measures. The pilot study provided additional knowledge that led to helping improve and significantly reducing the number

of errors. The pilot study allowed some unforeseen problems to be revealed and helped overcome some issues concerning the main study with some redesigning. Overall, this pilot study in the current research will be defined as a try-out of research techniques and methods, but also of questionnaires and interviews.

This pilot study was valuable for identifying unclear or ambiguous items for the actual research questionnaire. The actual research study was not inclusive of self-designed research interview questions for a pre- and post-test or for a behavior style/personality assessment within the research process. The piloting for use with existing tests is not necessary to determine what items should be removed or determine time limits and the clarity of instructions. Pre-testing could be essential to identify problems in the questionnaire, removing ambiguities and any other sources of bias and errors (Ali, 2016). The pre-test can also improve the reliability and validity of the interview questions.

There was not a pre-test done for the pilot study. The pilot study itself was essential to identify problems with the interview questions, removing ambiguities and other sources of bias and error (de Alwis, Martire, Äng, & Garme, 2016). The verbal and non-verbal behavior of participants in the pilot study gave valuable information about any embarrassment or discomfort experienced concerning the content or wording of items in a questionnaire.

The Pilot Study Application

The pilot study consisted of securing and interviewing 6 African Americans 65 and older, residing in rural Georgia towns after hospital closures occurred. After using

the approved measures and advertisements, there were 2 participants chosen from Folkston, Georgia; Jenkins County, Georgia, and Ellijay, Georgia who met the study protocol. The rural towns chosen for the pilot study were different from where the proposed study took place. The interviews took place in the research participant's homes. The interview atmosphere was encouraging. The interviewees were enthusiastic, and their attitudes towards the interview were positive. After a brief discussion with the participants, along with giving details of the interview, the pilot study participants consented to answer some interview questions.

The ten interview questions asked seemed relevant, but there were some questions more relevant than others. Questions 2 - 9 pertained to receiving delineative responses concerning the research participants' experiences after hospital closures occurred (see Appendix A). The interviews were carried out without observing any negativity and each research participant engaged wholly with the interviewer. Throughout the interview, none of the research participants had concerns after being asked throughout the interview process. October 6, 2018, and October 13, 2018, was agreed upon dates to conduct interviews. The first interviews completed in Folkston, and Jenkins County, Georgia went well. The other interviews were also engaging. The average interview lasted 10 minutes. The most extended interview was 20 minutes, and the shortest was 4 minutes.

Throughout the interview process, the pilot study participants had opportunities to provide give feedback on whether the questions were clear, simple, and easy-to-follow. Two participants gave limited, but well-received suggestions for improvements in format, and all others said the questions were clear and easy to answer. Smart PLS was used to

evaluate both the measurement and structural model considering that Smart PLS is suitable for handling small sample sizes (Putri, Yusof, Hasan, & Darma, 2017).

The pilot study results. The enumeration of the research design in the context of the pilot study enabled setting the tone and tenor for the original research on the path of objectivity. The framework of the pilot study enabled enumeration with the results of the pilot test for the full-scale study. The instruments developed enabled a smooth collection of data from the research participants. Table C1 shows the positive and negative responses compared to the total number of responses received for Questions 2–9. The table shows there were more negative responses than positive (see Appendix C). Questions 2–9 were also relative because they were questions where the response would help quantify the needed answers for the actual research study. Similarly, questions 2 – 9 were also the interview questions for the actual research study to gain detailed insight into the participant's experiences.

Among the pilot study participants, there were distinct differences between those who encountered negative experiences and positive experiences. Questions 2, 4, 5, 6 and 8 indicated higher negative experiences (M = 2, SD = 2.83) were encountered by the pilot study participants' (see Appendix C). Also, questions 3, 7, 9 showed the same similarities (M = 2, SD = 1.41) in relation to the participants' (see Appendix C). One conclusion of the pilot study is hospital closures in rural areas in Georgia had a profound and negative impact on African Americans 65 and older.

The mean age of the pilot study participants was 77 years of age with a standard deviation of 9.63. The pilot study results concluded that African Americans 65 and older

would be able to complete the questionnaires in the present wording. Also, the pilot study validated and provided satisfactory information to proceed with the actual research. Furthermore, the pilot study provided credence that the research questions and the research participant sample size are feasible for the actual research study and are feasible without changes to the protocol. It is determined to commence the actual study by securing participants for the study.

Chapter 4: Results

Introduction

I conducted this study to explore the experiences encountered by African Americans 65 and older, previously treated for an emergency medical condition after hospital closures that served rural counties. The closed hospitals were the principal and nearest facilities for receiving immediate access to treatment. There were 2 research questions: "What were the experiences with accessing immediate treatment for African Americans who are 65 and older living in Stewart and Webster County after the hospital closures?" and "How did African Americans 65 and older living in Stewart and Webster County find other health care services after the hospitals' closures?"

The purpose of this study was to explore the lived experiences of African Americans 65 and older residing in rural Georgia counties. The life course chart guided the data analysis. The aim was to view the narrative against the subjective viewpoints of the participants. Participants had working theories of their experiences, which formed part of the oral and written cultural texts of the group they are part of (Fotokian, Farahnaz, Fallahi-Khoshknab, & Pourhabib, 2017). The individual and collective experiences of participants gave meaning to their experiences (Wolgemuth et al., 2015). Exploring the participants' theories of interpretation helped acknowledge the participants' actions and uncover their narratives.

Chapter 4 describes the pilot study and the qualitative analysis of the data including the practical steps involved in the analysis. In the qualitative phase, data are analyzed into generative themes and described individually (Rocha, Alonso, López

Mares-Tamayo, & McGovern, 2016). Giving detailed descriptions helps provide clarity when the themes overlap (Colorafi & Evans, 2016).

Pilot Study Review

A pilot study was necessary to help refine the research topic, the study methods, and determine the best research methods to use (Vandenbroucke & Pearce, 2018). A pilot study also helped with the discovery of unforeseen issues in the research and determining whether a research project was feasible (Watson, 2016). Therefore, I conducted a pilot study to help advocate the research strategy, which included addressing logistical issues such as checking the instructions for comprehension, checking the wording of surveys, and checking the reliability and viability of results. The pilot study consisted of securing and interviewing 6 African Americans 65 and older who were residing in rural Georgia towns after hospital closures occurred. After using approved measures and advertisements, I chose 2 participants each from Folkston, Jenkins County, and Ellijay who met the research study protocol. The rural towns chosen for the pilot study were different from where the current study took place. The interviews took place in participants' homes.

The participants were asked Interview Questions 2-9 to gain detailed insight into their experiences. Participants' responses to Questions 2-9 also helped quantify the needed answers for the research study (see Appendix C). Table C1 shows the positive and negative responses compared to the total number of responses received for questions 2–9. The table shows that there were more negative responses than positive (see Appendix C). Questions 2, 4, 5, 6 and 8 indicated higher negative experiences (M = 2, SD

= 2.83) were encountered by the pilot study participants (see Appendix C). Questions 3, 7, 9 showed the same similarities (M = 2, SD = 1.41) in relation to the research participants (see Appendix C). The mean age of the pilot study participants was 77 years of age with a standard deviation of 9.63.

The pilot study results indicated that African Americans 65 and older could complete the actual research study questionnaires in the present wording. The pilot study also validated and provided adequate information to proceed with the current study. Furthermore, the pilot study supported that the research questions and the sample size were feasible for this study without changes to the protocol.

Setting and Demographics

There were not any personal or organizational conditions that influenced the participants or their experience at the time of the study that could have influenced the interpretation of the study results. The demographics of this study included 8 African Americans 65 and older residing in the rural Georgia counties of Stewart and Webster. The participants were residents treated for a previous emergency medical condition. Stewart and Webster counties are rural areas in western Georgia. The hospital closure caused these counties to lose immediate access to a nearby hospital that was utilized to treat emergency medical conditions.

Data Collection

Conducting 8 interviews with the participants helped gather their descriptions and the meanings of the central themes in their lives. The 8 participants were African Americans 65 and older residing in the rural Georgia counties of Stewart and Webster

Counties. Each participant was chosen based on being treated for a previous medical emergency, which required emergency treatment before and after the hospital closure occurred. The average interview lasted 10 minutes; the most extended interview was 20 minutes, and the shortest was 4 minutes. The participants were interviewed individually in their homes, as this was their preference. I recorded the interviews using a small camera and wrote notes as the participants expressed their experiences.

After the interviews were concluded, reading and transcribing the transcripts helped provide an overall understanding of the participants' experiences. Understanding the participants' details helped identify trends or recurring patterns that reflected what the participants felt most strongly about and how they expressed their experiences and emotions. There were no variations in the data collection plans as described in Chapter 3, and there were not any unusual circumstances encountered with the data collection process.

Data Analysis Process

The analytical process denotes the relationship between data collection and data analysis, which distinguishes qualitative research from traditional research (Chong, 2019). Analysis transforms data into findings by bringing structure and meaning to the collected data (Ward et al., 2017). Further, research questions can be answered through data interpretation (Sherif, 2018), as the researcher interprets the data during analysis (Kross, & Giust, 2019). Analyzing the data included making sense of the data through acknowledging similarities and differences (Mertens et al., 2017). I also explored the data using flexibility, open-mindedness, improvisation, and creativity (Donahue, & Foster-

Johnson, 2018). Accordingly, during the data transcribing and translating, there was a need to identify patterns of expressions that caused an awareness of similar or divergent themes as more data unfolded.

Identifying salient themes, recurring ideas, and patterns of belief that linked the participants was a challenging phase of data analysis (Weller, Blackburn, Borgatti, Gravlee, & Johnson, 2018). I placed clustered recurring patterns and commonalities in generative themes while making sure participants' expressions were represented in the expounded meanings, interpretations, and significances general themes common to all participants (Jeong & Othman, 2016). Additionally, the interpretation process guided theme generation (Iivari, 2018). Generating themes with an awareness of the individualized participant particularities and generalizations helped to understand and make sense of other participant responses, which is a goal of data analysis (Belotto, 2018). Theme analysis involved putting participants' expressions into a chosen theme while taking note of other participants who might have indicated something different (Kelly, Dowling, & Millar, 2018). Individual theme content varied throughout the interview process.

Creating an order with the different patterns and commonalities of participant expressions included coding. The first type of coding was open coding, which included reviewing the data for ideas as to how the patterns could be clustered and coded (Manouchehri, Hamidi, Sajadi, & Honari, 2016). The process of open coding allowed the identified patterns to be named, then taking the relevant parts and breaking them down,

scrutinizing them, comparing similarities and differences, then questioning the phenomena (Schary & Cardinal, 2016).

I named the clustered patterns or themes, each theme depending on its focus or subject matter, by highlighting their associated narrative. Conceptualizing the data represents a phenomenon and was done by comparing similar phenomena as given the same name (Schmidt, Colvin, Hohlfeld, & Leon, 2018). The name given to each theme or category was logically related to the data it represented the most.

Axial coding was also done to discover links and connections between the themes so that related themes merged into clusters (Jia, Chen, & Long, 2018). Axial coding explained how the categories or themes could be consistent from an internal perspective while being different from one another. Using axial coding helped highlight themes and align themes with different participants' similar narratives. Axial coding also allowed critical evaluations of the apparent patterns that were plausible and alternative explanations for the data (Bruscaglioni, 2016).

Selective coding was also considered for this study. Selective coding involved reviewing all themes or the combined participants' themes, then dividing the number selected that comprised the final presentation (Rivera, Gligor, & Sheffi, 2016). Each participant experienced the need for urgent treatment for their medical conditions since the hospital closures occurred in their town. The examples utilized do not include the actual names of the participants but rather pseudonyms to protect their privacy. For example, Rosa G., a 73-year-old African American woman living in Webster County, has congestive heart failure, and she described an instance of feeling lightheaded and having

chest pains. Rosa called the local EMS to assist her, but it took them 35 minutes to arrive at her home. When the ambulance arrived, Rosa asked the EMS personnel why it took so long and was told they were working a car accident.

Another example is Bob M., who is an 86-year-old African American man living in Stewart County and suffered a stroke as he was sitting on his front porch one afternoon. Bob's head began hurting, which in his past was a sign of a stroke. Bob tried to call the local EMS system, and twice the line was busy. Once Bob was able to make contact, the operator stated that it would take about 20 minutes before the EMS would arrive. Bob was able to get his neighbor to drive him to the hospital in the nearest town, where he received a diagnosis of having a minor stroke.

Since these occurrences, the participants' families made changes to help with medical treatment if the need arises; this was similar to other participants. The participants expressed their thankfulness to their families that made significant changes in their living arrangements to assist them. The participants shared they believed that if their families were not nearer, they were confident their reoccurring conditions would possibly lead to their deaths.

Evidence of Trustworthiness

The validity and reliability of the research are justified by using four methods to ensure credibility, transferability, dependability, and confirmability: using data triangulation, recording the interviews, using approved consent forms, and member checking. Data triangulation includes using multiple data sources, maintaining ongoing contact throughout the process of data collection, and obtaining consent to stay in touch

with the participants concerning the findings (Moon, 2019). Recording the interviews also ensured the quality of the data and transcribing the data for later use. Recording the interviews was conducted with direct permission of the participants and was accomplished with a video camera.

Third, I used consent forms that were IRB approved and ensured fairness and capability. The consent form provided validation from the research participants for recording the intended information and outlining the information as part of the research study. Finally, I used member checking, which was a significant aspect of verification and validity. Member checking was ongoing and coincided with the semi structured interviews and informal conversations with the participants and their family members if approved by the research participants. Member checking was used to check the collected data and helped establish the truth of the study's findings.

Results

Personal lifestyle choices influenced by various changes in an individual's life and can have a positive or negative impact (Barry, Greenhalgh, & Fahy, 2018). These changes can manifest through challenges with an individual's social interactions or mobility (Stol, Asscher, & Schermer, 2017). When people age, the impact of these changes may cause different experiences, and each person identifies with these experiences differently. How these changes affect individuals' lives across the life course may have some influences with their well-being as they age.

The participants experienced changes when hospital closures occurred in their towns. Each participant's change was associated with securing alternatives for receiving

treatment with their medical condition when the need arose. Exploring the participants' experiences and transitions were undertaken using the life course chart (see Appendix B). The life course chart helped to examine their developments over time after hospital closures occurred and if they were affected by those developments. The life course chart is also beneficial for showing how the participants constructed their lives through the choices and actions taken based on opportunities and constraints (Yingwattanakul & Moschis, 2017).

There were 8 in-depth qualitative interviews, 4 in Webster County, Georgia, and 4 in Stewart County, Georgia, with individuals treated for previous emergency medical conditions. The interviews were conducted in these 2 towns because the closed hospital served and was the nearest emergency medical treatment facility for the individuals residing in these towns. The details and analysis below give some details of the participants' lifestyle choices and trajectories, mainly how hospital closures affected the life course. The details incorporate pseudonyms and not the actual participants' names to protect their privacy.

Rosa G. is a 73-year-old African-American woman with congestive heart failure who lives in Webster County, which she grew up in. Rosa had heart issues when she was younger due to a heart arrhythmia that developed when she was 30. Rosa's husband of 25 years died 3 years ago. Rosa and her husband did not have any children, and her siblings have moved away to other towns and states. Rosa is a retired educator, and she receives benefits due to her retirement, along with Social Security and Medicaid. Rosa no longer drives due to poor eyesight but relies on her one of her neighbors to assist her with

shopping, outings, or doctors' visits if the need arises. Rosa's neighbor is a 35-year-old single mother of two, and Rosa will help provide care with her children when her neighbor is working at night.

Due to Rosa's congestive heart failure, she uses oxygen daily, which at one point was not necessary, but her heart condition has become worse as she aged. The organization where she purchases her oxygen delivers it to her home weekly if necessary. Rosa was admitted to the hospital near her residence twice before its closure and four times with 3 years. Rosa did not have any admissions to a hospital since the closure of the hospital near her town, but she received medical treatment at the hospital located about 25 minutes away from her residence at least ten times within the past 3 years. Rosa does not own a computer but knows how to use one.

Rosa does have a house phone along with a cellular phone. Rosa's living siblings visit her, but usually just on holidays due to the distance they live from one another. Rosa's home was about a 5 or 7 minute drive from the hospital that used to be open. The location of Rosa's doctor's office was in the local hospital before the closure, but her doctor relocated to Columbus, Georgia, about 25 minutes from Rosa's home. Rosa limits her doctor's visits unless needed or scheduled due to the distance she has to travel. Rosa's health care options as it relates to receiving urgent medical treatment is to use the hospital located about 25 minutes away and ask her neighbor or a family member to drive her to receive treatment or call the local EMS.

Elizabeth M. is a 87-year-old African-American woman with type 2 diabetes. Elizabeth's diagnosis of diabetes occurred while she was in her 30s, and as she aged, her

diabetes became worse. Due to complications from diabetes, Elizabeth had both legs amputated just below the knees. Elizabeth currently lives in Webster County with a male companion who is also elderly, but he is capable of driving her limited distances. Elizabeth's companion drives her to doctor's appointments if they are close to her residence and other nearby places she needs to go. Although Elizabeth's companion is her primary means of transportation, she also has a neighbor who assists her. Elizabeth is a retired nurse and receives retirement benefits along with Social Security and Medicaid.

Elizabeth has medications to treat her diabetes, but her blood sugar has dropped several times. Although Elizabeth uses medications, her blood sugar dropped in the past, causing her to become admitted to the hospital nearest to her residence. Elizabeth's blood sugar has dropped significantly enough causing her to become comatose for about 2 weeks in the hospital before its closure. Since the hospital closure occurred, Elizabeth was admitted to the hospital nearest to her residence twice within 2 years, and she received urgent care treatment several times that was related to her blood sugar dropping.

Elizabeth owns and uses a cell phone, along with her personal computer very well. Elizabeth does not have any living siblings or children. Due to Elizabeth's nursing experience, she understands the appropriate types of care she needs for her diabetes. Elizabeth's doctor's office is about twenty minutes from her residence. Elizabeth's health care options as it relates to receiving urgent medical treatment is driving to the hospital located about 20 minutes away from her residence, call the local EMS or ask a family member drive her to receive treatment.

Johnny H. is a 68-year-old African-American man with Chronic Obstructive Pulmonary Disease. Johnnie currently lives in Webster County, Georgia with his wife of 38 years. Johnny's wife is in good health and helps him when necessary. Johnny is retired from a manufacturing plant, and works part-time cooking at a local restaurant. Johnny still drives, has a cellular phone and laptop, and is well-versed with both. Johnny currently smokes 2 packs of cigarettes daily. Johnny currently visits his doctor, but he and his wife also understand that smoking is a primary concern and the cause of his illness. Johnny admissions to the hospital where he resides occurred 3 times within a year before its closure.

Johnny was admitted twice within the past 2 years to another hospital located about 45 minutes from where he resides. Johnny has several siblings, none reside in Webster County, and he has 3 children who reside in other towns. The location of Johnny's doctor's office is 30 minutes from where he lives. Johnny uses oxygen occasionally if he is short of breath, but this does not occur every day. The organization where he purchases oxygen is located about 20 from his home, but they deliver the oxygen to his home. Johnny's health care options as it relates to receiving urgent medical treatment include driving to the hospital located about 45 minutes away, call the local EMS, or have a family member drive him to receive treatment.

Larry M. is a 93-year-old African American man who lives in Webster County, Georgia, who has grand mal seizures. Larry has been having seizures since he was 18 years old due to a head injury. The seizure activity increased as Larry became older, and due to the seizures, Larry is unable to drive. Larry has 5 children that live in Webster

County, but Larry's wife passed away 10 years ago. Larry is a retired truck driver, and he receives retirement compensation, Medicaid, and Medicare. Larry has some siblings that reside in various counties, but none live within 10 miles of Webster County.

Larry is not technologically savvy; he does not own a computer but has a cell phone. Larry takes his medications as prescribed, along with visiting his doctor's office when scheduled. Some of Larry's children drive for him, which includes attending the appointments with his doctor. Due to Larry's seizure activity increasing, having a hospital closer to his residence was invaluable. Larry was admitted to the local hospital 16 times in a 3years period before its closure. Since the closure of the hospital, Larry received treatment due to falls related to seizure activities at a nearby hospital 5 or more times in the past 2 years. Larry was also admitted to the same hospital 3 times in the past year.

Although Larry's seizure activity has increased, he lives alone. Since Larry lives alone, he has several neighbors that routinely check on him and one neighbor he gave keys to his home. Larry was found unconscious in his home, but responsive on more than one occasion by his neighbor due to his seizure activity. Larry's current health care options as it relates to receiving urgent medical treatment are driving to the hospital located about an hour away, call the local EMS, or ask a family member or neighbor to drive him for treatment.

Bob M. is an 86-year-old African-American man treated in the past for multiple strokes. Bob lives in Stewart County. Bob's admissions to the hospital nearest to his residence occurred 5 times within four years prior to its closure. Bob was treated several

times at a hospital further from his home on multiple occasions within the past 3 years. Bob moved to Stewart County with his mom when he was 15 years old because his parents separated. Bob's parents are deceased, but he has 1 son from a previous relationship. The mother of Bob's son is deceased, and Bob does not have any living siblings. Bob is a retired farmer and receives Medicare, but he does not receive retirement benefits. Bob's son sends him money occasionally, when Bob asks.

Bob's strokes are related to high blood pressure that developed when he was in his twenties. Bob shows reluctance to taking the medicine that is prescribed. Bob lived about 15 minutes from the hospital prior to its closure. Bob has several neighbors who visit and help him. Bob does not have a doctor that he sees regularly and believes he does not need a doctor unless he gets sick. Bob owns a cell phone, which he purchases minutes for usage. There are instances when Bob does not have money to purchase minutes, and his phone is not usable. During those times, Bob can call for emergency assistance. Bob also does own a car. Bob's health care options as it relates to receiving urgent medical treatment includes driving to the hospital located about thirty minutes away, call the local EMS, or ask a family member to drive him to receive treatment.

Jeffery N. is a 71-year-old African-American man who resides in Stewart County, Georgia with his wife of 44 years. Jeffery and his wife share three children, who reside in varying counties throughout the state of Georgia. Jeffery also has other siblings; some reside in Stewart County and other towns throughout Georgia. Jeffery has ischemic heart disease caused by obesity. Jeffery weighs approximately 350 pounds and is 5 feet tall. Jeffery has a history of high blood pressure currently treated with 3 different blood

pressure medications. Jeffery maintains all of his scheduled doctors' appointments and ensures he completes all medications prescribed for his heart problems. Jeffery is a retired mechanic, and occasionally does some mechanical work when he is able. Jeffery receives retirement compensation, along with Medicaid. Jeffery still drives himself, but his wife also assists him with driving when needed.

Jeffery has a highly technological cellular phone and uses his personal computer with excellent skills and knowledge. Jeffery also makes valid attempts to walk 3 or 4 times daily to aid with weight loss. Jeffery was admitted to the hospital closest to his residence 4 times within a year prior to its closure. Jeffery has also received immediate medical treatment related to his heart illness 6 times in the past 2 years at the hospital furthest from his home. Jeffery has a good understanding of his medical needs and makes viable attempts to ensure he maintains optimal health. Jeffery's health care options as it relates to receiving urgent medical treatment includes driving to the hospital located about twenty-five away from his residence, call the local EMS or ask a family member to drive him to receive treatment.

Michelle J. is an 80-year-old African-American woman that had a recent major heart attack, which was her second in less than a year. Michelle did not have any significant medical issues or any foreseen reasons for a heart attack to occur. Michelle was admitted to the hospital further from her residence about a year ago when she had a second heart attack. When Michelle had the first heart attack, it was needful to admit her to the hospital nearest to her home, but it has since closed. Michelle lives in Stewart County, Georgia, where she was born and raised. Michelle's husband recently passed

away, but all her living siblings still reside in Stewart County, Georgia. Michelle and her siblings care for each other, but they consider Michelle as the mother figure because she is the oldest. Michelle has 4 children that reside in various states throughout the world. Michelle retired from the State of Georgia as a Social Worker, and receives retirement benefits, Medicaid, and Medicare. Michelle takes all her medications, and she maintains each of her doctor's appointments as needed.

Michelle is technologically savvy, and owns a desktop and laptop computer. Michelle also has a cellular phone with updated technological capabilities. Michelle still drives and owns several vehicles. Michelle takes her medications as directed, and her doctor's office is near his home. Michelle's home was about ten minutes from the hospital before its closure. Michelle's health care options as it relates to receiving urgent medical treatment is driving to the hospital located about forty minutes away, call the local EMS, or ask a family member to drive her to receive treatment.

William M. is a 69-year-old African-American man residing in Stewart County, Georgia. William has end-stage cirrhosis of the liver, and is on the transplant list to receive a new liver. If William does not receive a liver transplant, his doctor stated William has less than 2 years to live. William is an admitted alcoholic and presently drinks 2 or more beers a week. William attended some alcoholic anonymous meetings but believed they were wasteful and not helpful meetings. William believes if he is going to die, it will occur on his terms. William is a retired high school principle, and blames the stress of his past employment as a cause for drinking. William receives retirement benefits, Medicaid, and Medicare. William also made several investments during the time

he was employed, which garnered him a good return on his investments. William understands the risk and the possible deadly outcomes associated with consuming alcohol.

William does take prescribed medications and maintains his doctor's appointments. William has never been married and does not have any children. William was also an only child but his other relatives who reside in the northern parts of the world. William still drives but has been charged three times with driving under the influence in the past ten years. William was admitted 15 times within three years to the local hospital before its closure. William has been admitted 3 times within the past 2 years to the hospital located about 25 miles from where he resides. William was also treated for several medical urgencies 21 times in the past 2 years for incidents or accidents related to his drinking. William does own a laptop and desktop computer, as well as the most modern cellular phone. William's technologic skills are outstanding, and he comprehends how to engage with current technologic advancements.

William has neighbors and friend who assists him and transports him to an appointment and other activities. William's health care options as it relates to receiving urgent medical treatment is driving to the hospital located about 40 minutes away, call the local EMS, or ask a neighbor to drive her to receive treatment.

Summary

Themes emerged from the participant's narratives connected with the phenomenological approach, which helped understand the participant's experiences from their perspective (Victorino et al., 2018). The coding processes allowed themes to be understood while presenting the findings of the research in a coherent and meaningful way (Anderson, Brouwer, Wendorf, & Cahill, 2016). After completing and compiling each type of coding, 2 themes emerged from participant narratives.

1. Participants' fears and doubts about receiving urgent treatment for their medical conditions.

The narratives from the participants placed a high value on their desire for a local or closer urgent treatment facility. The participants talked about their fears, anxieties, and uncertainty concerning receiving timely treatment for their medical conditions if warranted. Each participant expressed significant doubts as to where, how, and in what way they could receive treatment for their medical conditions in an urgent situation. Each participant feared their conditions would get worse if the need arose to seek treatment further than where they resided.

2. Negative expressions from the participant's viewpoints related to their experiences they encountered due to hospital closures.

Each participant experienced the need for urgent treatment for their medical conditions after the hospital closures occurred. When asked about their thoughts concerning the hospital closures, each participant expressed anger, discouragement, feelings of despair,

and hopelessness. All the participants communicated doubts and uncertainty for obtaining immediate treatment for their medical condition elsewhere. The participants did not state any advantageous or positive experiences concerning hospital closures.

The themes did not overlap, although the participants expressed individual beliefs more negatively concerning the hospital closures. All participants expressed anger, frustration, and confusion about possible treatment options since the closure of the hospitals near their perspective living areas. The participants shared their concerns, including conflicting feelings and thoughts about their future urgent medical needs not being met. The research data showed emerging themes indicating the meaningful ways the participant's expressed their narratives. There were negative feelings seen and spoken based on the participant's experiences since the hospital closures occurred. Furthermore, each participant's narrative reflected in distinctive ways the social context against which they had life experiences.

Generating themes gave credence to noticing trends of expressions and emotions similar to all participants. These trends helped identify condensations' and generalizations without removing life circumstances particular to each research participant (Surmiak, 2018). While interpreting thematic data and compiling different themes simultaneously, the processes for analysis and interpretation was complete (Berber, Köle, Taşçı, & Can, 2018).

The research questions aimed to investigate the encounters experienced by African Americans 65 and older living in Stewart and Webster County after hospital closures. The primary research question was, "What are the experiences with accessing

immediate treatment for African Americans 65 and older living in Stewart and Webster County after the hospital closures? The answer to this research question is the participants' encountered negative experiences on a higher level than positive experiences with accessing immediate treatment.

The secondary research question was, "How did African Americans 65 and older living in Stewart and Webster County find other health care services after the hospital closures? The answer to this research question was the participants encountered and would need to make various changes to receive treatment for the critical medical conditions. The inclusion of family and friends was relevant for each research participant and was helpful with their treatment options. In chapter 5, there will be a summary of the research findings and recommendations for the research study. Also, the results of the theme analysis were patterns of expressions generated in consecutive sessions, which often indicated a more positive slant are explained further in Chapter 5.

Chapter 5: Discussions, Conclusions, and Recommendations

Introduction

I explored the lived experiences of 8 African Americans 65 and older residing in the rural Georgia counties of Stewart and Webster. The participants were treated for a previous emergency medical condition. The objectives of this research study were to:

1. Explore the experiences caused by seeking immediate medical treatment or alternatives not located in town.
2. Identify the impact hospital closures had with participants' medical conditions.
3. Evaluate the personal challenges and if the participants have overcome those challenges for receiving treatment with emergency medical conditions.
4. Analyze the type of communication the participants encountered with local health authorities concerning hospital closures and the alternative given for emergency medical condition treatment.
5. Explore the participants' family interaction and involvement with receiving treatment for emergency medical conditions as a result of hospital closures.

Chapter 5 presents a summary of the findings, recommendations, and conclusions based on the data analyzed in Chapter 4. The interpretation of the findings is organized based on the research objectives.

Interpretations of the Findings

I used nonprobability sampling, which helped obtain answers to the research questions (Kline, 2017). Eight respondents took part in this research using prepared, structured, and pretested interview questions. The Smart PLS computer program allowed coding the interview answers and analysis of the research findings. The findings discussed in this chapter revealed both genders equally represented in the sample.

Objective 1

The findings of the research revealed that all respondents expressed negative experiences, feelings of anxiety, and fear based on their inability and having the lack of availability for alternative treatment options. Each participant appeared doubtful about receiving assistance and treatment if confronted with the need for immediate care for their medical condition.

Objective 2

According to the findings, the participants were more accustomed to receiving treatment at the medical facility nearest to their residence. The respondents indicated that in general, they were less compliant to the treatment requiring long-distance travel to another health care facility for urgent treatment. The major hurdle based on their response was not related to having the funds pay someone for transportation but the lack of EMS reliability or availability to take them.

The participants all seemed unhappy with their treatment options, and some were not knowledgeable enough to monitor their conditions closely. Participants were also less motivated to seek treatment if they needed to travel further distances. Although the

participants did not express that they were financially incapable, they stated that their lack of nearby access was a significant problem.

Objective 3

The findings revealed that the participants felt stigmatized. The challenges each of the participants encountered indicated the rural areas where they reside as a limitation for receiving urgent medical treatment. Each of the respondents indicated that they did not feel ashamed of the fact they resided in a rural area, and they did not desire to move out of the rural areas to receive the urgent treatment if the need arose. Participants felt isolated and segregated because their perception was hospital closures impacted elderly African Americans in their towns more, as this population comprised most of the residents living in their town.

Objective 4

The participants indicated that they did not hear about the hospital closures in a manner conducive with securing urgent treatment if necessary. They stated that there was not any long-term or short-term strategies implemented and communicated to them concerning alternatives for receiving urgent medical treatment. The participants also believed that they were not involved in the choices about the hospital closures, and with any decisions concerning treatment alternatives.

Furthermore, participants believed the decisions to close the hospitals in their towns may have been warranted, but the lack of advising residents with treatment alternatives by those who made the determinations for closures was irresponsible.

Objective 5

Every participant acknowledged that their family and friends were significant factors for assisting them after hospital closures occurred. The following describes changes that the research participants' families did to help. The research participants' names have been changed to pseudonyms to protect their privacy:

- Rosa's niece moved in with her to drive her to a hospital further away if needed.
- The son of Elizabeth's male companion moved closer to where she and he reside.
- Johnny's daughter and her children moved in with him to assist with his medical needs.
- Larry's youngest son took a job in Columbus and moved in with Larry to assist him with his medical needs.
- Bob's son sold his home in another county and purchased a home nearer to Bob to assist him if an urgent medical need arose.
- Jeffery's brother and Jeffery moved into a rental house together so that Jeffery would have the necessary medical assistance if needed.
- Michelle's grandson transferred to a job near her residence and moved into an apartment closer to where she lives to assist with medical treatment if the need arose.

- One of William's cousins offered to move him in with them where there is a hospital. William refused their offer, so a neighbor moved in with him to assist him with his medical needs if necessary.

Findings in Relation to Framework

The conceptual framework for this study was the health belief model, which is a psychological and behavioral theory composed of 2 components of health-related behavior: the desire to avoid illness or get well if already ill and the belief that a specific health action will prevent, or cure, illness. The research validated the inclusion of a local hospital, or a hospital nearer to rural areas could help prevent critical medical conditions from worsening. The health belief model suggested that the participants had some perceived susceptibility. Their subjective perception of the risk of acquiring an illness or disease associated with their already diagnosed medical condition would become more significant. Thus, the health belief model provided validation that there is a variation in a person's feelings of personal vulnerability to an illness or disease.

Findings in Relation to Pilot Study. The framework of the study enabled the enumeration of the results of the research study. The enumeration of the research design in connection with the pilot study also enabled a tone and tenor for the path of objectivity. The instruments enabled the smooth collection of data from the target group. The survey percentages defined the number of positive and negative responses compared to the total number of responses received. Interview Questions 2–9 allowed the percentage of each response to be calculated and asked during the pilot study. These research questions seemed relative because they would help quantify the needed answers.

Additionally, calculating the median as a measure of central tendency due to the ordinal scale of answers was necessary. Table C4 shows the actual results in their numeral form (see Appendix C).

Table C4 shows that 50% of the respondents described their medical conditions negatively. The participants were treated multiple times for their medical conditions at the hospital nearest to their towns before the hospital closures occurred. Each participant was also treated several times at the hospital furthest away from the residence several times since hospital closures occurred. Table C4 also shows that 50% of the research participants encountered negative experiences as they related to their knowledge that hospital closures were occurring in their town. The participants stated that either they were not notified or were not notified within enough time to seek urgent care if necessary.

Seventy-five percent of participants also viewed themselves as lost, left out, or not as safe as it related to how they see themselves with receiving urgent care for their medical condition if needed. Furthermore, 87% of the respondents experienced significant stress due to hospital closures that occurred in their town related to the distance they would need to travel if they experienced a need for urgent care. Similarly, at least 87% of the respondents had negative challenges for securing solutions to receiving urgent care for their medical conditions when it became needed. The respondents noted that one of the changes they encountered involved moving to areas closer to where there was a hospital still open.

Seventy-five percent of participants also expressed that it would have been their desire to have the hospital closest to their living environments remain open. The respondents experienced more negative experiences as it related to hospital closures, but their family and friend became a more significant support system.

More than 62% of the respondents shared their families and friends became more involved in their in-home care options, urgent treatment alternatives, and offered to help them relocate. Family and friends, as well as relocating, were options, but 50% of the respondents stated that they had no confidence in their local EMS. The respondents stated that in the past and present, the EMS was usually slow in their response times. The respondents also were discouraged and showed disbelief in the EMS ability to serve multiple counties and multiple calls (see Appendix C).

Limitations of the Study and Recommendations

Their limitations seen while or after conducting this research study were that the sample size is too small. The other limitations were the questionnaire used for the interview processes and the phenomenological research limitations. The recommendations for addressing these limitations were using a confidence interval that gave an estimated range of values which was likely to include an unknown population parameter. Also, sending the interview questions to the participants before the interview process was helpful. I worded the interview questions in a manner that participants were able to choose their terms when answering questions. Avoiding wording the interview questions to avoid influencing the answers was beneficial. Lastly, the participants were guided during the interviews if necessary, so the focus stayed on topic.

The objectives of the research study are met based on the descriptions given by the participants and the findings of this research. There were reasons which could cause disparities for African Americans 65 and older in Georgia's rural counties. The disparities may arise due to hospital closures in rural areas. The following provides some possible reasons that could cause disparities due to the closure of hospitals in rural areas:

1. Disproportionate risk of lacking access to care, and experiencing worse health outcomes.
2. Limited overall gains in the quality of care and health for the broader population.
3. Lack of access to a vast array of knowledgeable and interrelated individuals, providers, health systems, and other urgent medical treatment factors.
4. Increased difficulty in accessing urgent medical treatment services.
5. Increased difficulties and persistent barriers caused by health care treatment facilities that are not accessible.
6. Decreases with health care quality.
7. The lack of essential health care service to meet the scope of demands.
8. The lack of addressing rural-specific characteristics as it relates to meeting urgent treatment need.
9. The lack of collaborating across all types of health care to provide better care and better utilization of what is already tautly stretched health care and treatment resources.

The recommendations for this research study are to:

1. Conduct further research related to the actual health care, racial, and cultural disparities caused.
2. Conduct further research, which includes the individual experiences of other races, ethnic groups, or, ages of specific populations residing in rural areas.
3. Reevaluate the research study participants' in a year to understand how, or in what ways their lives have changed due to hospital closures.

Implications

The positive social change associated with the study focuses on creating communicating and collaborative partnerships. The partnerships could occur between hospital administrators, governmental agencies, and communities. These partnerships can provide a promising avenue through which details and alternatives take place when hospital closures occur in or near rural communities. These partnerships may also circumvent the negative impact on the residents accustomed to having a hospital nearest to their homes. If these partnerships occur, it could lead to more effective outcomes for achieving the goal of having alternative emergency medical treatment facilities nearby. If reform efforts continue to grow the communities, perceived jeopardy towards the populations affected more could occur.

The research findings produced compelling evidence that hospital closures negatively impact 65 and older African Americans residing in rural areas. The rural area population include more than African Americans 65 and older, the objective of this research primarily focused on this group. The positive social change significance of the research centered on exploring the experiences encountered by the research participants

after rural hospitals closures and suggesting steps African Americans 65 and older could take in other rural towns to prepare for hospital closures.

The research could also be helpful for the state, local, and federal agencies to procure alternatives for receiving immediate treatment for emergency medical conditions in other rural towns after hospitals closures occur.

Conclusion

Chapter 5 presented a discussion of findings from a qualitative phenomenological hermeneutic study of 8 African Americans, 65 and older. The participants were treated for previous emergency medical conditions before and after hospital closures occurred. The participants' resided in the rural towns of Webster and Stewart County, Georgia. The participant's expectations transformed into beliefs about how their lives. The research questions were:

1. What are the experiences with accessing immediate treatment for African Americans who are 65 and older living in Stewart and Webster County after the hospital closures?
2. How did African Americans 65 and older living in Stewart and Webster County find other health care services after the hospital's closures?

The research findings answered the research questions and showed the participants encountered negative experiences on a higher level than positive experiences with accessing immediate treatment. Empirical evidence provided credence that the participants experienced additional changes in their treatment alternatives, which included their families and friends assisting. The distance, along with the lack of

immediate access for receiving immediate treatment for emergency medical conditions could also affect their health outcomes.

The research findings also determined that each participant encountered and would need to make different changes to receive treatment for urgent medical conditions. The inclusion of family and friends was relevant for each research participant and was helpful with their treatment options. The participants' had access to another hospital, but for each participant, the hospital was at least twenty miles away or further.

The research objectives for this study were defined and completed. The research findings produced compelling evidence that hospital closures negatively impact 65 and older African Americans residing in rural areas. The research concluded this generation believes hospital closures were not helpful, but harmful towards achieving positive health-related outcomes with their previously treated medical conditions. The research study also indicated some steps African Americans 65 and older can take in other rural towns when hospital closures occur such as:

- Think broadly about the factors that influence their health care decisions, treatment options, and outcomes.
- Reassess their options for obtaining their health care needs and other resources.
- Focus on what is most important concerning their health care treatment alternatives.
- Engaging a variety of stakeholders to assist them in obtaining alternatives for meeting their urgent treatment needs.

- Communicate with local, state and other agencies that help promote rural health care reform

Steps adapted from the work of Yoon, & Lee, 2018.

African Americans 65 and older residing in rural areas facing hospital closures have a voice in helping to establish policies and programs that will work for their community. The health-related needs of African Americans 65 and older, along with others who reside in rural communities, may require a firm understanding of local priorities, needs, assets, and values from all parties involved. Continual and collective engagement from those residing in rural communities, and local or state governing agencies is not a guarantee that hospital closures will not occur. The collaboration could create opportunities relative to health care treatment and provisions that promote physical, mental, and social well-being of all involved.

References

Affordable Care Act. (n.d.). Retrieved from https://health care.gov

Affordable Care Act Medicaid Expansion. (n.d.). Retrieved from http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx

Afro-American. (n.d.). In *Merriam-Webster's dictionary*. Retrieved from https://www.merriamwebster.com/dictionary/Afro-American

Al Alami, S. (2015). Research within the field of applied linguistics: Points to consider. *Theory and Practice in Language Studies, 5*(7), 1330. doi:10.17507/tpls.0507.0

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. *International Journal of Education and Literacy Studies, 5*(2), 9-19. doi:10.7575/aiac.ijels.v.5n.2p.9

Alhassan, R. K., & Nketiah-amponsah, E. (2016). Frontline staff motivation levels and health care quality in rural and urban primary health facilities: A baseline study in the Greater Accra and western regions of Ghana. *Health Economics Review, 6*(1), 1-11. doi:10.1186/s13561-016-0112-8

Ali, M. M. (2016). Are we asking the same questions in different contexts: Translation techniques in cross-culture studies in science education? *Journal of Turkish Science Education, 13*(1). doi:10.12973/tused.10155a

Allen, E. M., Call, K. T., Beebe, T. J., McAlpine, D. D., & Johnson, P. J. (2017). Barriers to care and health care utilization among the publicly insured. *Medical Care, 55*(3), 207-214. doi:10.1097/MLR.0000000000000644

American College of Emergency Physicians. (2014). Retrieved from

https://www.acep.org

Anderson, R. E., Brouwer, A. M., Wendorf, A. R., & Cahill, S. P. (2016). Women's behavioral responses to the threat of a hypothetical date rape stimulus: A qualitative analysis. *Archives of Sexual Behavior, 45*(4), 793-805. doi:10.1007/s10508-015-0682-2

Andrews, C. (2014). Unintended consequences: Medicaid expansion and racial inequality in access to health insurance. *Health & Social Work, 39*(3), 131-133. doi:10.1093/hsw/hlu024

Ang, C. K., Embi, M. A., & Yunus, M. M. (2016). Enhancing the quality of the findings of a longitudinal case study: Reviewing trustworthiness via ATLAS.ti. *The Qualitative Report, 21*(10), 1855-1867. doi:10.18260/p.24010

Ayanian, J. Z. (2015, October 1). The cost of racial disparities in healthcare. *Harvard Business Review*. Retrieved from https://hbr.org/2015/10/the-costs-of-racial-disparities-in-health-care

Babitsch, B., Gohl, D., & von Lengerke, T. (2012). Re-revisiting Andersen's behavioral model of health services use: A systematic review of studies from 1998–2011. *GMS Psycho-Social-Medicine, 9*(11). doi:10.3205/psm000089

Bacsu, J. R., Jeffery, B., Johnson, S., Martz, D., Novik, N., & Abonyi, S. (2012). Healthy aging in place: Supporting rural seniors' health needs. *Online Journal of Rural Nursing and Health Care, 12*(2), 77-87. doi:10.1080/03601277.2013.802191

Baernholdt, M., Yan, G., Hinton, I., Rose, K., & Mattos, M. (2012). Quality of life in rural and urban adults 65 years and older: Findings from the national health and

nutrition examination survey. *The Journal of Rural Health, 28*(4), 339-347. doi:10.1111/j.1748-0361.2011.00403.x

Baillie, L. (2015). Promoting and evaluating scientific rigour in qualitative research. *Nursing Standard (2014+), 29*(46), 36. doi:10.7748/ns.29.46.36.e8830

Balasubramanian, S., & Jones, E. C. (2016). Hospital closures and the current healthcare climate: The future of rural hospitals in the USA. *Rural and remote health, 16*(3935). Retrieved from https://pdfs.semanticscholar.org/4a3e/fc43d74975bcc4ffab57bd44d97b5ea7b5f3.pdf

Barratt, H., Harrison, D. A., Fulop, N. J., & Raine, R. (2015). Factors that influence the way communities respond to proposals for major changes to local emergency services: a qualitative study. *PloS one, 10*(3). doi:10.1016/j.healthpol.2015.04.015

Barrera, M., Jr., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: a progress report. *Journal of Consulting and Clinical Psychology, 81*(2), 196. doi:10.1037/a0027085

Barrilleaux, C., & Rainey, C. (2014). The politics of need: Examining governors' decisions to oppose the "Obamacare" Medicaid expansion. *State Politics & Policy Quarterly, 14*(4), 437-460. doi:10.1177/1532440014561644

Barry, E., Greenhalgh, T., & Fahy, N. (2018). How are health-related behaviours influenced by a diagnosis of pre-diabetes? A meta-narrative review. *BMC Medicine, 16*. doi:10.1186/s12916-018-1107-6

Bastain, R., Garner, M., Barron, J., Akowuah, E., & Mase, W. (2016). Georgia's rural

hospital closures: The common-good approach to ethical decision-making. *Journal of Georgia Public Health Association, 5*(4). doi:10.21663/jgpha.5.417

Bazzoli, G. J., Lee, W., Hsieh, H.-M., & Mobley, L. R. (2012). The effects of safety net hospital closures and conversions on patient travel distance to hospital services. *Health Services Research, 47*(1), 129-150. doi:10.1111/j.1475-6773.2011.01318.x

Bazzul, J. (2015). The sociopolitical importance of genetic, phenomenological approaches to science teaching and learning. *Cultural Studies of Science Education, 10*(2), 495-503. doi:10.1007/s11422-014-9605-0

Beck, T. W. (2013). The importance of a priori sample size estimation in strength and conditioning research. *The Journal of Strength & Conditioning Research, 27*(8), 2323-2337. doi:10.1519/JSC.0b013e318278eea0

Belotto, M. J. (2018). Data analysis methods for qualitative research: Managing the challenges of coding, interrater reliability, and thematic analysis. *The Qualitative Report, 23*(11), 2622-2633. Retrieved from https://nsuworks.nova.edu/tqr/vol23/iss11/2/

Berber, Ş., Köle, M., Taşçı, M. E., & Can, E. (2018). From past to present born global phenomenon: A thematic analysis 1. *Economics and Business Review, 4*(2), 80-97. doi:10.18559/ebr.2018.2.5

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative Health Research, 24*(1), 136-144. doi:10.1177/1049732313519710

Bhan, N., Madhira, P., Muralidharan, A., Kulkarni, B., Murthy, G. V. S., Basu, S., & Kinra, S. (2017). Health needs, access to healthcare, and perceptions of aging in

an urbanizing community in India: a qualitative study. *BMC Geriatrics, 17*(1), 156. doi:10.1186/s12877-017-0544-y

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research, 26*(13), 1802-1811. doi:10.1177/1049732316654870

Bischoff, R. J., Springer, P. R., & Taylor, N. (2017). Global mental health in action: Reducing disparities one community at a time. *Journal of Marital and Family Therapy*, *43*(2), 276-290.doi:10.1111/jmft.12202

Black, K., Dobbs, D., & Young, T. L. (2015). Aging in community mobilizing a new paradigm of older adults as a core social resource. *Journal of Applied Gerontology*, *34*(2), 219-243. doi:10.1177/0733464812463984

Bleich, S. N., Jarlenski, M. P., Bell, C. N., & LaVeist, T. A. (2012). Health inequalities: Trends, progress, and policy. *Annual Review of Public Health, 33*(7). doi:10.1146/annurevpublhealth-031811-124658

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research, 19*(4), 426-432. doi:10.1108/qmr-06-2016-0053

Bragg, E. J., & Hansen, J. C. (2015). Ensuring care for aging baby boomers: Solutions at hand. *Generations, 39*(2), 91-98. Retrieved from https://www.researchgate.net

Brame, T. (2017). The immediate effects of rural hospital closures. *AJN The American Journal of Nursing*, *117*(11), 10. doi:10.1097/01.NAJ.0000526725.22292.8b

Bruscaglioni, L. (2016). Theorizing in grounded theory and creative abduction. *Quality and Quantity, 50*(5), 2009-2024. doi:10.1007/s11135-015-0248-3

Bryant, P. H., Hess, A., & Bowen, P. G. (2015). Social determinants of health related to obesity. *The Journal for Nurse Practitioners, 11*(2), 220-225. doi:10.1016/j.nurpra.2014.10.027

Burgin, M., de Vey Mestdagh, C. N., &, J. (2015). Consistent structuring of inconsistent knowledge. *Journal of Intelligent Information Systems, 45*(1), 5-28. doi:10.1007/s10844-013-0270-7

Burkey, M., Bhadury, J., Eiselt, H., & Toyoglu, H. (2017). The impact of hospital closures on geographical access: Evidence from four southeastern states of the United States. *Operations Research Perspectives, 4*56-66. doi:10.1016/j.orp.2017.03.003

Butler, J. L. (2016). Rediscovering Husserl: Perspectives on the epoché and the reductions. *The Qualitative Report, 21*(11), 2033-2043. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss11/8

Cai, J., Coyte, P. C., & Zhao, H. (2017). Decomposing the causes of socioeconomic-related health inequality among urban and rural populations in China: A new decomposition approach. *International Journal for Equity in Health, 16* doi:10.1186/s12939-017-0624-9

Caldwell, J. T., Ford, C. L., Wallace, S. P., Wang, M. C., & Takahashi, L. M. (2016). Intersection of living in a rural versus urban area and race/ethnicity in explaining access to health care in the United States. *American Journal of Public Health, 106*(8), 1463-1469. doi:10.2105/AJPH.2016.303212

Camillo, C. A. (2016). The US healthcare system: Complex and unequal. *Global Social*

Welfare, 3(3), 151-160. doi:10.1007/s40609-016-0075-z

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-7. doi:10.1188/14.ONF.545-547

Carey, T. A., Haviland, J., Tai, S. J., Vanags, T., & Mansell, W. (2016). MindSurf: A pilot study to assess the usability and acceptability of a smartphone app designed to promote contentment, well-being, and goal achievement. *BMC Psychiatry, 16*. doi:10.1186/s12888-016-1168-z

Casey, M. M., Moscovice, I., Holmes, G. M., Pink, G. H., & Hung, P. (2015). Minimum distance requirements could harm high-performing critical-access hospitals and rural communities. *Health Affairs, 34*(4), 627-635. doi:10.1377/hlthaff.2014.0788

Cassie, C. G., Moeckli, J., Cram, P. M., & Heather, S. R. (2017). Introduction of tele-ICU in rural hospitals: Changing organisational culture to harness benefits. *Intensive & Critical Care Nursing, 40*, 51-56. doi:10.1016/j.iccn.2016.10.001

Castleberry, A., & Nolen, A. (2018). Thematic analysis of qualitative research data: Is it as easy as it sounds?. *Currents in Pharmacy Teaching and Learning*, *10*(6), 807-815. doi:10.1016/j.cptl.2018.03.019

Chang, C. Y., Abujaber, S., Reynolds, T. A., Camargo, C. A., & Obermeyer, Z. (2016). Burden of emergency conditions and emergency care usage: New estimates from 40 countries. *Emergency Medicine Journal: EMJ, 33*(11), 794. doi:10.1136/emermed-2016-205709

Chanta, S., Mayorga, M., & McLay, L. (2014). Improving emergency service in rural

areas: a bi-objective covering location model for EMS systems. *Annals Of Operations Research*, *221*(1), 133-159. doi:10.1007/s10479-011-0972-6

Chin, M. H. (2015). Advancing equity in healthcare. *BMJ: British Medical Journal (Online), 350*. doi:10.1136/bmj.h1617

Choi, S. K., Adams, S. A., Eberth, J. M., Brandt, H. M., Friedman, D. B., Tucker-Seeley, R. D., Mei, Y., & Hébert, J. R. (2015). Medicaid coverage expansion and implications for cancer disparities. *American Journal of Public Health*, *105*(S5), S706-S712. doi:10.2105/AJPH.2015.302876

Chokshi, D. A., Chang, J. E., & Wilson, R. M. (2016). Health reform and the changing safety net in the united states. *The New England Journal of Medicine, 375*(18), 1790-1796. doi:10.1056/NEJMhpr1608578

Chong, S. L. (2019). Making critical connections: How to apply the analytic guiding frame (AGF) and overall guiding frame (OGF) in qualitative data analysis. *The Qualitative Report, 24*(2), 298-306. Retrieved from https://nsuworks.nova.edu/tqr/vol24/iss2/8

Cohort. (2017). In *Merriam-Webster's dictionary*. Retrieved from https://www.merriamwebster.com/dictionary/cohort

Colorafi, K. J., & Evans, B. (2016). Qualitative descriptive methods in health science research. *HERD: Health Environments Research & Design Journal, 9*(4), 16-25. doi:10.1177/1937586715614171

Converse, M. (2012). Philosophy of phenomenology: How understanding aids research. *Nurse Researcher, 20*(1), 28. doi:10.7748/nr2012.09.20.1.28.c9305

Cook, J. A., Beard, D. J., Cook, J. R., & MacLennan, G. S. (2016). The curious case of an internal pilot in a multicentre randomised trial - time for a rethink? *Pilot and feasibility studies*, *2*(1), 73. doi:10.1186/s40814-016-0113-8

Countouris, M., Gilmore, S., & Yonas, M. (2014). Exploring the impact of a community hospital closure on older adults: a focus group study. *Health & Place*, *26*143-148. doi:10.1016/j.healthplace.2013.11.008

Critical access hospitals. (2017). Retrieved from http://www.aha.org/advocacy-issues/cah/index.shtm

Cronin, C. E. (2017). The prevalence of community benefit participation in hospital region and its relationship to community health outcomes. *Journal of Health & Human Services Administration*, *40*(1). 98-132. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1923995876?accountid=14872

Daher, M., Carré, D., Jaramillo, A., Olivares, H., & Tomicic, A. (2017). Experience and meaning in qualitative research: A conceptual review and a methodological device proposal. *Forum: Qualitative Social Research, 18*(3). doi:10.17169/fqs-18.3.2696

Daniels, K., & Auguste, T. (2013). Moving forward in patient safety: multidisciplinary team training. *In Seminars in Perinatology, 37* (3), 146-150. doi:10.1053/j.semperi.2013.02.004

Darin-Mattsson, A., Fors, S., & Kareholt, I. (2017). Different indicators of socioeconomic status and their relative importance as determinants of health in old age. *International Journal for Equity in Health, 16*.

doi:10.1186/s12939-017-0670-3

Das, S., Mitra, K., & Mandal, M. (2016). Sample size calculation: Basic principles. *Indian Journal of Anesthesia, 60*(9). doi:10.4103/0019-5049.190621

Davis, D. (2016). A practical overview of how to conduct a systematic review. *Nursing Standard (2014+), 31*(12), 60. doi:10.7748/ns.2016.e10316

de Alwis, Manudul Pahansen;., Martire, R. L., Äng, B. O., & Garme, K. (2016). Development and validation of a web-based questionnaire for surveying the health and working conditions of high-performance marine craft populations. *BMJ open, 6*(6). doi:10.1136/bmjopen-2016-011681

Diehm, C. (2015). Telling stories of ourselves in places. *Nature + Culture, 10*(2), 250-256. doi:10.3167/nc.2015.100206

Dickman, S. L., Himmelstein, D. U., & Woolhandler, S. (2017). Inequality and the health-care system in the USA. *The Lancet, 389*(10077), 1431-1441. doi:10.1016/S0140-6736(17)30398-7

Disproportionate share hospital. (2017). Retrieved from https://www.princetonreview.com/careers/76/health-care-administrator

Dixon-Woods, M., Kocman, D., Brewster, L., Willars, J., Laurie, G., & Tarrant, C. (2017). A qualitative study of participants views on re-consent in a longitudinal biobank. *BMC Medical Ethics, 18*. doi:10.1186/s12910-017-0182-0

Donahue, C., & Foster-Johnson, L. (2018). Liminality and transition: Text features in postsecondary student writing. *Research in the Teaching of English, 52*(4), 359-381. Retrieved from

https://www.researchgate.net/publication/326110115_Liminality_and_transition_Text_features_in_postsecondary_student_writing

Dowling, M., & Cooney, A. (2012). Research approaches related to phenomenology: Negotiating a complex landscape. *Nurse Researcher, 20*(2), 21-27. doi:10.7748/nr2012.11.20.2.21.c9440

Du, Y., & Xu, Q. (2016). Health disparities and delayed health care among older adults in California: A perspective from race, ethnicity, and immigration. *Public Health Nursing*, *33*(5), 383-394. doi:10.1111/phn.12260

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis. *Sage Open, 4*(1). doi:10.1177/2158244014522633

Eldridge, S., Bond, C., Campbell, M., Hopewell, S., Thabane, L., Lancaster, G., & Coleman, C. (2015). Defining feasibility and pilot studies in preparation for randomised controlled trials: using consensus methods and validation to develop a conceptual framework. *Trials*, *16*(2), O87. doi:10.1186/1745-6215-16-S2-O87

Englander, M. (2012). The interview: Data collection in descriptive phenomenological human scientific research. *Journal of Phenomenological Psychology, 43*(1), 13-35. doi:10.1163/156916212X632943

Epstein, A. M., Sommers, B. D., Kuznetsov, Y., & Blendon, R. J. (2014). Low-income residents in three states view Medicaid as equal to or better than private coverage, support expansion. *Health Affairs, 33*(11), 2041-7. doi:10.1377/hlthaff.2014.0747

Evandrou, M., Falkingham, J., Feng, Z., & Vlachantoni, A. (2016). Ethnic inequalities in limiting health and self-reported health in later life revisited. *Journal of*

Epidemiology and Community Health, 70(7), 653. doi:10.1136/jech-2015-206074

Evangelista, V. (2016). The geographics of patients transfers: The case of an Italian regional health system. *GeoJournal, 81*(5), 771-778. doi:10.1007/s10708-015-9662-

Feazel, L., Schlichting, A. B., Bell, G. R., Shane, D. M., Ahmed, A., Faine, B., Nugent, A., Mohr, N. M. (2015). Achieving regionalization through rural interhospital transfer. *The American Journal of Emergency Medicine, 33*(9), 1288-1296. doi:10.1016/j.ajem.2015.05.032

Federal Office of Rural Health Policy. (2019). *Rural Health Information Hub*. Retrieved from Find rural data: https://www.ruralhealthinfo.org/

Fielding, J., & Kumanyika, S. (2009). Current issue: Recommendations for the concepts and form of Healthy People 2020. *American Journal of Preventive Medicine, 37*255-257. doi:10.1016/j.amepre.2009.04.029

Finlay, L. (2012). Debating phenomenological methods. Hermeneutic phenomenology in education, 17-37. doi:10.1007/978-94-6091-834-6

Fiscella, K., & Sanders, M. R. (2016). Racial and ethnic disparities in the quality of health care. Annual review of public health, 37, 375-394. doi:10.1146/annurevpublhealth032315-021439

Fleet, R., Audette, L. D., Marcoux, J., Villa, J., Archambault, P., & Poitras, J. (2014). Comparison of access to services in rural emergency departments in Quebec and British Columbia. *Canadian Journal of Emergency Medicine, 16*(6), 437-448. doi:10.1017/S1481803500003456

Ford, D. M. (2016). Four persistent rural healthcare challenges. *Healthcare Management Forum*, *29*(6). doi:10.1177/0840470416658903

Ford, J. A., Wong, G., Jones, A. P., & Steel, N. (2016). Access to primary care for socioeconomically disadvantaged older people in rural areas: a realist review. *BMJ open*, *6*(5), e010652. doi:10.1136/bmjopen-2015-010652

Fotokian, Z., Farahnaz, M. S., Fallahi-Khoshknab, M., & Pourhabib, A. (2017). The empowerment of elderly patients with chronic obstructive pulmonary disease: Managing life with the disease. *PLoS One*, *12*(4). doi:10.1371/journal.pone.0174028

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. Retrieved from https://nsuworks.nova.edu/tqr/vol20/iss9/3

Gautam, S., Hicks, L., Johnson, T. & Mishra, B. (2013). Measuring the performance of critical access hospitals in Missouri using data envelopment analysis. *The Journal of Rural Health, 29*(2), 150–158. doi:10.1111/j.1748-0361.2012.00439.x

Georgia Consumer and Community Groups. (2014). *Strengthening Georgia's rural hospitals and increasing access to care*. Retrieved from https://www.georgiawatch.org/wp-content/uploads/2015/01/RHSC-Formal-Report-1.pdf

Gelber, S. E., Grünebaum, A., & Chervenak, F. A. (2016). Reducing health care disparities: A call to action. *American Journal of Obstetrics & Gynecology, 215*(2), 140-142. doi:10.1016/j.ajog.2016.06.058

Gelling, L. (2015). Stages in the research process. *Nursing Standard (2014+), 29*(27), 44. doi:10.7748/ns.29.27.44.e8745

Gentili Ph.D., M., Harati, P., & Serban Ph.D., N. (2016). Projecting the impact of the affordable care act provisions on accessibility and availability of primary care providers for the adult population in Georgia. *American Journal of Public Health, 106*(8), 1470-1476. doi:10.2105/AJPH.2016.303222

Gentles, S. J., Charles, C., Nicholas, D. B., Ploeg, J., & McKibbon, K. A. (2016). Reviewing the research methods literature: Principles and strategies illustrated by a systematic overview of sampling in qualitative research. *Systematic Reviews, 5.* doi:10.1186/s13643-016-0343-0

Gittner, L. S. (2015). Empowering patients to become partners. *Journal of Health and Human Services Administration, 38*(2), 276-288. doi:10.1377/hblog20140724.040288

Gittner, L. S., Clochesy, J. M., Gutierrez, J. O., & Robinson, J. L. (2015). Be heard: Healthcare perspectives from medically and socially disenfranchised communities. *Journal of Health and Human Services Administration, 38*(2), 215-236. Retrieved from http://www.jstor.org/stable/24463891

Glor, E. D. (2014). Studying the impact of innovation on organizations, organizational populations, and organizational communities: a framework for research. *The Innovation Journal*, *19*(3), 1.

Governing. (2017). 2012 State population census estimates. Retrieved from https://www.governing.com/gov-data/state-census-population-migration-births-

deaths-estimates.html

Hadziabdic, E., Lundin, C., & Hjelm, K. (2015). Boundaries and conditions of interpretation in multilingual and multicultural elderly healthcare. *BMC Health Services Research, 15*. doi:10.1186/s12913-015-1124-5

Halcomb, E., & Hickman, L. (2015). Mixed methods research. *Nursing Standard (2014+), 29*(32), 41. doi:10.7748/ns.29.32.41.e8858

Halfon, N., Larson, K., Lu, M., Tullis, E., & Russ, S. (2014). Lifecourse health development: past, present, and future. *Maternal and Child Health Journal, 18*(2), 344. doi:10.1007/s10995-013-1346-2

Hamel, M. B., Blumenthal, D., & Collins, S. R. (2014). Health care coverage under the Affordable Care Act. A progress report. *The New England Journal of Medicine,371*(3), 275-81. doi:10.1056/NEJMhpr1405667

Han, X., Nguyen, B. T., Drope, J., & Jemal, A. (2015). Health-related outcomes among the poor: Medicaid expansion vs. non-expansion states. *PloS one, 10*(12). doi:10.1371/journal.pone.0144429

Hanssens, L. G. M., Devisch, I., Janique, L. C., & Willems, S. (2016). Accessible health care for roma: A gypsys tale an in-depth qualitative study of access to health care for roma in Ghent. *International Journal for Equity in Health, 15* doi:10.1186/s12939-016-0327-7

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental causeof population health inequalities. *American Journal of Public Health, 103*(5), 813-821. doi:10.2105/AJPH.2012.301069

Haynes, V. (2016). The road to cultural competency: Are we there yet? *Kansas Nurse, 91*(1), 11-14. doi:10.1097/01.NURSE.0000410308.49036.73

Hazra, A., & Gogtay, N. (2016). Biostatistics series module 5: Determining sample size. *Indian Journal of Dermatology, 61*(5) doi:10.4103/0019-5154.190119

Heinonen, K. (2015). Van Manen's method and reduction in a phenomenological hermeneutic study. *Nurse Researcher (2014+), 22*(4), 35. doi:10.7748/nr.22.4.35.e1326

Health Resources and Services Administration. (2019, May). Rural hospital programs. Retrieved from https://www.hrsa.gov/rural-health/rural-hospitals/index.html

Healthy People 2020: Disparities (2015). Retrieved from https://www.healthypeople.gov/2020/about/foundation-healthmeasures/Disparities

Hepworth, M., Grunewald, P., & Walton, G. (2014). Research and practice: a critical reflection on approaches that underpin research into people's information behaviour. *Journal of Documentation*, *70*(6), 1039-1053. doi:10.1108/JD-02-2014-0040

Henry, M., Rivera, J., & Faithful, G. E. (2015). The four principles of phenomenology. *Continental Philosophy Review*, *48*(1), 1-21. doi:10.1007/s11007-014-9313-1

Herman, B. (2014). Georgia Rolls Out Plan to Save Struggling Rural Hospitals. *Becker's Hospital Review.* Retrieved from https://www.beckershospitalreview.com/hospital-management-administration/georgia-rolls-out-plan-to-save-struggling-rural-hospitals.html

Høiseth, M., & Keitsch, M. M. (2015). Using phenomenological hermeneutics to gain understanding of stakeholders in healthcare contexts. *International Journal of Design, 9*(3). Retrieved from http://www.ijdesign.org/index.php/IJDesign/article/view/1947/709

Holmes, M. (2015). Financially fragile rural hospitals mergers and closures. *North Carolina Medical Journal, 76*(1), 37-40. doi:10.18043/ncm.76.1.37

Hsia, R. Y., Srebotnjak, T., Maselli, J., Crandall, M., McCulloch, C., & Kellermann, A. L. (2014). The association of trauma center closures with increased inpatient mortality for injured patients. *The Journal of Trauma and Acute Care Surgery,76*(4), 1048. doi:10.1097/TA.0000000000000166

Iivari, N. (2018). Using member checking in interpretive research practice. *Information Technology & People, 31*(1), 111-133. doi:10.1108/ITP-07-2016-0168

Immonen, M., Vilko, J., Koivuniemi, J., & Laasonen, K. (2015). Outcomes of public health reform–service availability in rural areas. *International Journal of Public Sector Management, 28*(1), 42-56. doi:10.1108/IJPSM-03-2014-0035

Iglehart, J. K. (2018). The challenging quest to improve rural health care. *The New England Journal of Medicine, 378*(5), 473-479. doi:10.1056/NEJMhpr1707176

James, W. L. (2014). All rural places are not created equal: Revisiting the rural mortality penalty in the United States. *American Journal of Public Health, 104*(11). doi:10.2105/AJPH.2014.301989

Jia, W., Chen, H., & Long, R. (2018). Determining multi-layer factors that drive the carbon capability of urban residents in response to climate change: An

exploratory qualitative study in china. *International Journal of Environmental Research and Public Health, 15*(8), 1607. doi:10.3390/ijerph15081607

Jeong, H., & Othman, J. (2016). Using interpretative phenomenological analysis from a realist perspective. *The Qualitative Report, 21*(3), 558-570. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss3/9

Johnson, Jr, J. H., & Lian, H. (2018). Vulnerable African American seniors: The challenges of aging in place. *Journal of Housing for the Elderly, 32*(2), 135-159. doi:10.1080/02763893.2018.1431581

Jones, C. L., Jensen, J. D., Scherr, C. L., Brown, N. R., Christy, K., & Weaver, J. (2015). The health belief model as an explanatory framework in communication research: exploring parallel, serial, and moderated mediation. *Health communication, 30*(6), 566-576. doi:10.1080/10410236.2013.873363

Jørgensen, D. (2015). Philosophy at a crossroads. *Philosophy Today, 59*(4), 611-625. doi:10.5840/philtoday201510784

Jost, T. S. (2016). A critical year for the affordable care act. *Health Affairs, 35*(1), 8-11. doi:10.1377/hlthaff.2015.1458

Joynt, K. E., Chatterjee, P., Orav, E. J., & Jha, A. K. (2015). Hospital closures had no measurable impact on local hospitalization rates or mortality rates, 2003–11. *Health Affairs, 34*(5), 765-772. doi:10.1377/hlthaff.2014.1352

Health care administrator: A day in the life of a healthcare administrator. (n.d.) Retrieved from https://www.princetonreview.com

Kadam, P., & Bhalerao, S. (2010). Sample size calculation. *International Journal of*

Ayurveda Research, 1(1), 55–57. doi:10.4103/0974-7788.59946

Kafle, N. P. (2013). Hermeneutic phenomenological research method simplified. *Bodhi: An Interdisciplinary Journal*, *5*(1), 181-200. doi:10.3126/bodhi.v5i1.8053

Kannan, S., & Gowri, S. (2015). Pilot studies: Are they appropriately reported? *Perspectives in clinical research, 6*(4), 207. doi:10.4103/2229-3485.167097

Karunanayake, C. P., Rennie, D. C., Hagel, L., Lawson, J., Janzen, B., Pickett, W., Dosman, J., Punam, P., and Group, S. (2015). Access to specialist care in rural Saskatchewan: The Saskatchewan rural health study. *Healthcare, 3*(1), 84-99. doi:10.3390/healthcare3010084

Kelly, C., Hulme, C., Farragher, T., & Clarke, G. (2016). Are differences in travel time or distance to healthcare for adults in global north countries associated with an impact on health outcomes? A systematic review. *BMJ Open, 6*(11) doi:10.1136/bmjopen-2016-013059

Kelly, M., Dowling, M., & Millar, M. (2018). The search for understanding: The role of paradigms. *Nurse Researcher (2014+), 25*(4), 9. doi:10.7748/nr.2018.e1499

Kim, H., Lee, S., Cheon, J., Hong, S., & Chang, M. (2018). A comparative study to identify factors of caregiver burden between baby boomers and post baby boomers: A secondary analysis of a US online caregiver survey. *BMC Public Health, 18*. doi:10.1186/s12889-018-5488-4

King, J., & Redwood, Y., (2016). The healthcare institution, population health, and black lives. *Journal of the National Medical Association, 108*(2), 131-136. doi:10.1016/j.jnma.2016.04.002

Kistin, C. J. (2015). Address persistent racial disparities in academic medicine to improve healthcare quality. *Evidence-Based Medicine, 20*(6), 191. doi:10.1136/ebmed-2015-110308

Kline, T. J. B. (2017). Sample issues, methodological implications, and best practices. *Canadian Journal of Behavioural Science, 49*(2), 71-77.doi:10.1037/cbs0000054

Kok, J. (2007). Principles and prospects of the life course paradigm. In *Annales de démographie historique*. (1) pp. 203-230. doi:10.3917/adh.113.0203

Koopman, O. (2015). Phenomenology as a potential methodology for subjective knowing in science education research. *Indo-Pacific Journal of Phenomenology, 15*(1), pp. 1-10. doi:10.1080/20797222.2015.1049898

Kross, J., & Giust, A. (2019). Elements of Research Questions in Relation to Qualitative Inquiry. *The Qualitative Report, 24*(1), 24-30. Retrieved from https://nsuworks.nova.edu/tqr/vol24/iss1/2

Kudo, S., Mutisya, E., & Nagao, M. (2015). Population aging: An emerging research agenda for sustainable development. *Social Sciences, 4*(4), 940-966. doi:10.3390/socsci4040940

Kullgren, J. T., McLaughlin, C. G., Mitra, N., & Armstrong, K. (2012). Nonfinancial barriers and access to care for US adults. *Health services research, 47*(1pt2), 462-485. doi:10.1111/j.1475-6773.2011.01308.x

Lalanda Nico, M. (2016). Bringing life “back into life course research”: Using the life grid as a research instrument for qualitative data collection and analysis. *Quality and Quantity, 50*(5), 2107-2120. doi:10.1007/s11135-015-0253-6

Lail, P. J., Laird, S. S., McCall, K., Naretto, J., & York, A. (2016). Facility closure: How to get in, get out, and get what is important. *Perspectives in Health Information Management, 13*(Fall). Retrieved from http://library.ahima.org/doc?oid=301957#.XSPIR_5RfIU http://search.proquest.com.ezp.waldenulibrary.org/docview/1838941180?accountid=14872

Lalanda Nico, M. (2016). Bringing life "back into life course research": Using the life grid as a research instrument for qualitative data collection and analysis. *Quality and Quantity, 50*(5), 2107-2120. doi:10.1007/s11135-015-0253-6

LaVeist, T. A., Gaskin, D., & Richard, P. (2011). Estimating the economic burden of racial health inequalities in the United States. *International Journal of Health Services, 41*(2), 231-238. doi:10.2190/HS.41.2.c

Lee, E. (2014). Designing service coverage and measuring accessibility and serviceability of rural and small urban ambulance systems. Systems, 2(1), 34-53. doi:10.3390/systems2010034

Lee, J. S., Zegras, P. C., & Ben-Joseph, E. (2013). Safely active mobility for urban baby boomers: The role of neighborhood design. Accident Analysis & Prevention, 61, 153-166. doi:10.1016/j.aap.2013.05.008

Leung, L. (2015). Validity, reliability, and generalizability in qualitative research. *Journal of Family Medicine and Primary Care, 4*(3), 324-327. doi:10.4103/2249-4863.161306

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centered access to health

care: conceptualizing access at the interface of health systems and populations. *International Journal for Equity in Health, 12*(1). doi:10.1186/1475-9276-12-18

Lichter, D. T., Parisi, D., & Taquino, M. C. (2012). The geography of exclusion: Race, segregation, and concentrated poverty. Social Problems, 59(3), 364-388. doi:10.1525/sp.2012.59.3.364

Lipsky, M. & Glasser, M. (2011). Critical access hospitals and the challenges to quality care. *The Journal of American Medical Association.306* (1). doi:10.1001/jama.2011.928.

Lin, D., Labeau, F., & Vasilakos, A. V. (2015). Qoe-based optimal resource allocation in wireless healthcare networks: Opportunities and challenges. *Wireless Networks, 21*(8), 2483-2500. doi: 10.1007/s11276-015-0927-y

Lu, Y., & Davidson, A. (2017). Fatal motor vehicle crashes in Texas: needs for and access to emergency medical services. *Annals Of GIS, 23*(1), 41-54. doi:10.1080/19475683.2016.1276102

Lynch, J. (2017). The three-legged stool: Why safety, quality, and equity depend on each other. *Journal of Healthcare Management, 62*(5), 298-301. doi:10.1097/JHM-D-17-00109

Lynch, S. (2013). Hospice and palliative care access issues in rural areas. *American Journal of Hospice and Palliative Medicine, 30*(2), 172-177. doi:10.1177/1049909112444592

MacArthur, K. R. (2017). Beyond health beliefs: The role of trust in the HPV vaccine decision making process among American college students. *Health Sociology*

Review, 26(3), 321-338. doi:10.1080/14461242.2017.1381035

Malagon-Maldonado, G. (2014). Qualitative research in health design. *HERD: Health Environments Research & Design Journal, 7*(4), 120-34. doi:10.1177/193758671400700411

Malone, H. E., Nicholl, H., & Coyne, I. (2016). Fundamentals of estimating sample size. *Nurse Researcher (2014+), 23*(5), 21. doi:10.7748/nr.23.5.21.s5

Manouchehri, J., Hamidi, M., Sajadi, S. N., & Honari, H. (2016). Designing a qualitative model of doping phenomenon effects on sport marketing in Iran. *Podium, 5*(2), 120-136. doi:10.5585/podium.v5i2.179

Mantwill, S., Monestel-Umaña, S., & Schulz, P. J. (2015). The relationship between health literacy and health disparities: A systematic review. *PLoS One, 10*(12) doi:10.1371/journal.pone.0145455

Manuel, J. I. (2017). Racial/ethnic and gender disparities in health care use and access. *Health Services Research*, doi:10.1111/1475-6773.12705

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, *3*(5), 551. doi:10.1037/h0023281

Marquand, A., & York, A. (2016). Squaring to the challenge: Who will be tomorrow's caregivers? *Generations, 40*(1), 10-17. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/1797672705?accountid=14872

Martin, D. (2015). Qualitative research - what makes it effective? Retrieved from http://www.sitepronews.com/2015/03/05/qualitative-research-makes-effective/

Mason, D. J. (2017). Rethinking rural hospitals. *JAMA: Journal of the American Medical*

Association, *318*(2), 114. doi:10.1001/jama.2017.7535

Matua, G. A., & Van, D. W. (2015). Differentiating between descriptive and interpretive phenomenological research approaches. *Nurse Researcher (2014+), 22*(6), 22. doi:10.7748/nr.22.6.22.e1344

McLaren, Z. M., Ardington, C., & Leibbrandt, M. (2014). Distance decay and persistent health care disparities in South Africa. *BMC Health Services Research*, *14*541. doi:10.1186/s12913-014-0541-1

McLaughlin, N. (2017). Movements, Sects and Letting Go of Symbolic Interactionism.\ *Canadian Journal of Sociology (Online)*, *42*(2), 203. Retrieved from https://journals.library.ualberta.ca/cjs/index.php/CJS/article/download/29342/21345

Mertens, E., Heylighen, A., Declercq, A., Hannes, K., Truyen, F., Denier, Y., & Dierckx, d. C. (2017). QualiBuddy: An online tool to improve research skills in qualitative data analysis. *Qualitative Research Journal, 17*(4), 306-318. doi:10.1108/QRJ-06-2016-0034

Mil, J. F., & Henman, M. (2016). Terminology, the importance of defining. *International journal of clinical pharmacy*, *38*(3), 709-713. doi:10.1007/s11096-016-0294-5

Milbourn, B., McNamara, B., & Buchanan, A. (2015). The lived experience of everyday activity for individuals with severe mental illness. *Health Sociology Review*, *24*(3), 270-282. doi:10.1080/14461242.2015.1034747

Milbourne, P., & Kitchen, L. (2014). Rural mobilities: Connecting movement and fixity in rural places. *Journal of Rural Studies*, *34*, 326-336.

doi:10.1016/j.jrurstud.2014.01.004

Miles, M., Chapman, Y., & Francis, K. (2015). Peeling the onion: Understanding others' lived experience. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 50*(2), 286-295. doi:10.1080/10376178.2015.1067571

Moher D, Liberati A, Tetzlaff J, Altman DG, the PRISMA group (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

Moon, M. D. (2019). Triangulation: A Method to Increase Validity, Reliability, and Legitimation in Clinical Research. *Journal of Emergency Nursing*, *45*(1), 103-105. doi:10.1016/j.jen.2018.11.004

Mou, J., Shin, D. H., & Cohen, J. (2016). Health beliefs and the valence framework in health information seeking behaviors. *Information Technology & People*, *29*(4), 876-900. doi:10.1108/ITP-06-2015-0140

Moy, P., & Murphy, J. (2016). Problems and prospects in survey research. *Journalism and Mass Communication Quarterly*, *93*(1), 16-37. doi:10.1177/1077699016631108

Muganga, L. (2015). The importance of hermeneutic theory in understanding and appreciating interpretive inquiry as a methodology. *Journal of Social Research & Policy, 6*(1), 65-88. Retrieved from https://search.proquest.com/openview/474bcbbfc5562ad61ca1d6ea38a14cd2/1?pq-origsite=gscholar&cbl=396321

Mullinix, K. J., Leeper, T. J., Druckman, J. N., & Freese, J. (2015). The generalizability

of survey experiments. *Journal of Experimental Political Science, 2*(2), 109-138. doi:10.1017/XPS.2015.19

Natafgi, N., Baloh, J., Weigel, P., Ullrich, F., & Ward, M. M. (2016). Surgical patient safety outcomes in critical access hospitals: How Do They Compare? *The Journal of Rural Health*. doi:10.1111/jrh.12176

National Association of Community Health Centers. (2013). Removing barriers to care: Community health centers in rural areas. Retrieved from http://nachc.org/wpcontent/uploads/2015/06/Rural_FS_1013.pdf

National Center for Health Statistics (2011). Health people 2020. Retrieved from http://www.cdc.gov/nchs/healthy_people/hp2020.htm

Nelson, M. S., Wooditch, A., & Dario, L. M. (2015). Sample size, effect size, and statistical power: A replication study of Weisbrod's paradox. *Journal of Experimental Criminology, 11*(1), 141-163. doi:10.1007/s11292-014-9212-9

Nelson, S., M.D. (2016). Race, racism, and health disparities: What can I do about it? *Creative Nursing, 22*(3), 161-165. doi:10.1891/10784535.22.3.161

Nielsen, A. H., & Angel, S. (2016). Consolation or confrontation when interacting through an ICU diary - A phenomenological-hermeneutical study. *Intensive & Critical Care Nursing, 37*, 4-10. doi:10.1016/j.iccn.2016.06.002

Office of Disease Prevention and Health Promotion. (2016). Health People 2020. Retrieved from https://www.healthypeople.gov/

Office of Policy Development and Research, U.S. Department of Housing and Urban Development. (2013). Aging in place: Facilitating choice and independence.

Retrieved from https://www.huduser.gov/portal/periodicals/em/fall13/highlight1.html

Olsen, L. (2015). The Affordable Care Act and the politics of the Medicaid expansion. *New Political Science,37*(3), 295-320. doi:10.1080/07393148.2015.1056428

Oxley, R. (2015). Parents' experiences of their child's admission to pediatric intensive care. *Nursing Children and Young People (2014+), 27*(4), 16. doi:10.7748/ncyp.27.4.16.e564

Padilla, C. M., Kihal-Talantikit, W., Perez, S., & Deguen, S. (2016). Use of geographic indicators of healthcare, environment, and socioeconomic factors to characterize environmental health disparities. *Environmental Health, 15.* doi:10.1186/s12940-016-0163-7

Pati, D., Gaines, K., & Valipoor, S. (2016). Delivering rural health in a changing health model. *HERD: Health Environments Research & Design Journal, 10*(1), 76-86. doi:10.1177/1937586716656443

Pati, D., & Lorusso, L. N. (2018). How to write a systematic review of the literature. *HERD: Health Environments Research & Design Journal, 11*(1), 15-30. doi:10.1177/1937586717747384

Pennel, C. L., Tamayo, L., Wells, R., & Sunbury, T. (2016). Emergency medical service based care coordination for three rural communities. *Journal of Health Care for the Poor and Underserved, 27*(4), 159-180. doi:10.1353/hpu.2016.0178

Percy, W. H., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report, 20*(2), 76-85.

Perneger, T. V., Courvoisier, D. S., Hudelson, P. M., & Gayet-ageron, A. (2015). Sample size for pre-tests of questionnaires. *Quality of Life Research, 24*(1), 147-151. doi:10.1007/s11136-014-0752-2

Perniss, P., & Vigliocco, G. (2014). The bridge of iconicity: from a world of experienceto the experience of language. *Phil. Trans. R. Soc. B, 369*(1651). doi:10.1098/rstb.2013.0300

Peters, K., & Halcomb, E. (2015). Interviews in qualitative research. *Nurse Researcher (2014+), 22*(4), 6. doi:10.7748/nr.22.4.6.s2

Porter, J. A., Haberling, K., & Hohman, C. (2016). Employer desired competencies for undergraduate health administration graduates entering the job market. *The Journal of Health Administration Education, 33*(3), 355-375. Retrieved from https://www.ingentaconnect.com/contentone/aupha/jhae/2016/00000033/.../art00002

Potter, A. J., M.A., Ward, M. M., PhD., Natafgi, N., M.P.H., Ullrich, F., MacKinney, A. C., Bell, L., M.H.A., & Mueller, K. J., PhD. (2016). Perceptions of the benefits of telemedicine in rural communities. *Perspectives in Health Information Management,* pp. 1-13. Retrieved from http://perspectives.ahima.org/wp-content/uploads/2017/06/PerceptionsofTelemedicine.pdf. Google Scholar

Price, J. A., Ana I F Sousa, S., Asante, A. D., Martins, J. S., Williams, K., & Wiseman, V. L. (2016). "I go I die; I stay I die, better to stay and die in my house": Understanding the barriers to accessing health care in Timor-Leste. *BMC Health Services Research, 16* doi:10.1186/s12913-016-1762-2

Price, C. C., & Eibner, C. (2013). For states that opt out of Medicaid expansion: 3.6 Million fewer insured and $8.4 billion less in federal payments. *Health Affairs,32*(6), 1030-1036. doi:10.1377/hlthaff.2012.1019

Prina, L. L. (2016). Grantwatch. *Health Affairs, 35*(1), 174-175. doi:10.1377/hlthaff.2015.148

Purnell, T. S., Calhoun, E. A., Golden, S. H., Halladay, J. R., Krok-Schoen, J. L., Appelhans, B. M., & Cooper, L. A. (2016). Achieving health equity: Closing the gaps in health care disparities, interventions, and research. *Health Affairs*, *35*(8), 1410-1415. doi:10.1377/hlthaff.2016.0158

Putri, N. T., Yusof, S. M., Hasan, A., & Darma, H. S. (2017). A structural equation model for evaluating the relationship between total quality management and employees' productivity. *International Journal of Quality & Reliability Management, 34*(8), 1138-1151. doi:10.1108/IJQRM-10-2014-0161

Ramamonjiarivelo, Z., Weech-Maldonado, R., Hearld, L., Menachemi, N., Epané, J. P., & O'Connor, S. (2015). Public hospitals in financial distress: Is privatization a strategic choice?. *Health care management review*, *40*(4), 337-347. doi:10.1097/HMR.0000000000000032

Ratcliffe, M., Burd, C., & Alison, F. (2016). Defining Rural at the U.S. Census Bureau. *American Community Survey and Geography Brief*. Retrieved from https://www2.census.gov/geo/pdfs/reference/ua/Defining_Rural.pdf

Reiter, K. L., Noles, M., & Pink, G. H. (2015). Uncompensated care burden may mean financial vulnerability for rural hospitals in states that did not expand Medicaid.

Health Affairs, 34(10), 1721-1729. doi:10.1377/hlthaff.2014.1340

Rivera, L., Gligor, D., & Sheffi, Y. (2016). The benefits of logistics clustering. *International Journal of Physical Distribution & Logistics Management, 46*(3), 242-268. doi:10.1108/IJPDLM-10-2014-0243

Roberts, P., & Green, B. (2013). Researching rural places on social justice and rural education. *Qualitative Inquiry, 19*(10), 765-774. doi:10.1177/1077800413503795

Robeznieks, A. (2014). Georgia governor acts to bolster faltering rural hospitals. Retrieved from http://www.modernhealthcare.com/article/20140430/NEWS/304309961

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*(1), 25-41. doi:10.1080/14780887.2013.801543

Rocha, J., Alonso, L., López Mares-Tamayo, M. J., & McGovern, E. R. (2016). Beyond theoretical sensitivity: The benefits of cultural intuition within qualitative research and Freirean generative themes - four unique perspectives. *The Qualitative Report, 21*(4), 744-764. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss4/10.

Rowley, J. (2014). Designing and using research questionnaires. *Management Research Review, 37*(3), 308-330. doi:10.1108/MRR-02-2013-0027

Rubin, I. L. (2015). Cycle of environmental health disparities. *Journal of Alternative Medicine Research, 7*(2), 165-176. doi:10.1515/ijdhd-2012-0054

Salmon, J. (2015). Using observational methods in nursing research. *Nursing Standard*

(2014+), 29(45), 36.doi:10.7748/ns.29.45.36.e8721

Sampoornam, W. (2015). Hermeneutic circle focusing lived experience of breast cancer survivorship- A phenomenological approach. *Asian Journal of Nursing Education and Research, 5*(3), 439-442. doi:10.5958/2349-2996.2015.00088.9

Scanlan, J. P. (2014). Race and mortality revisited. *Society, 51*(4), 328-346. doi:10.1007/s12115-014-9790-1

Schary, D. P., & Cardinal, B. J. (2016). Starting to uncover the mystery of interdisciplinary research in kinesiology. *Physical Educator, 73*(2), 213-229. doi:10.18666/TPE-2016-V73-I2-6184

Schmidt, B., Colvin, C. J., Hohlfeld, A., & Leon, N. (2018). Defining and conceptualising data harmonisation: A scoping review protocol. *Systematic Reviews, 7*. doi:10.1186/s13643-018-0890-7

Schulz, A., Zoller, D., Nickels, S., Beutel, M. E., Blettner, M., Wild, P. S., & Binder, H. (2017). Simulation of complex data structures for planning of studies with focus on biomarker comparison. *BMC Medical Research Methodology, 17* doi:10.1186/s12874-017-0364-y

Scott, J., Lyons, A., & MacPhail, C. (2015). Desire, belonging and absence in rural places. *Rural Society, 24*(3), 119-226. doi:10.1080/10371656.2015.1099263

Scuffham, P. A., Moretto, N., Krinks, R., Burton, P., Whitty, J. A., Wilson, A., Kendall, E. (2016). Engaging the public in healthcaredecision-making: Results from a citizens' jury on emergency care services. E*mergency Medicine Journal: EMJ, 33*(11), 782. doi:10.1136/emermed-2015-205663

Setia, M. (2016). Methodology series module 5: Sampling strategies. *Indian Journal of Dermatology, 61*(5) doi:10.4103/0019-5154.190118

Seymour, J. W., Polsky, D. E., Brown, E. J., Barbu, C. M., & Grande, D. (2017). The role of community health centers in reducing racial disparities in spatial access to primary care. *Journal Of Primary Care & Community Health*, *8*(3), 147-152. doi:10.1177/2150131917699029

Sharfstein, J., Fontanarosa, P. B., & Bauchner, H. (2013). Critical issues in US health care: health care on the edge. *Jama*, *310*(18), 1945-1946. doi:10.1001/jama.2013.282124

Shartzer, A., Long, S. K., & Anderson, N. (2016). Access to care and affordability have improved following affordable care act implementation; problems remain. *Health Affairs, 35*(1), 161-168. doi:10.1377/hlthaff.2015.0755

Sherif, V. (2018). Evaluating preexisting qualitative research data for secondary analysis. *Forum: Qualitative Social Research, 19*(2). doi:10.17169/fqs-19.2.2821

Siren, A., & Haustein, S. (2013). Baby boomers' mobility patterns and preferences: What are the implications for future transport? *Transport Policy, 29*, 136-144. doi:10.1016/j.tranpol.2013.05.001

Skea, D. (2015). Deconstructing Caring and Authentic Measurement. *International Journal of Caring Sciences*, *8*(2). 427-434. Retrieved from https://www.semanticscholar.org/paper/Deconstructing-Caring-and-Authentic-Measurement-Skea-Cert/097bcf8daaac702d9b76852484d15f1bbbb02533

Skea, D., & Cert, P. (2016). Phenomenological enquiry and psychological research in

caring and quality of life contexts: Acknowledging the invisible. *International Journal*, *9*(2), 1134. Retrieved from https://www.researchgate.net/publication/312639484_Special_Article_Phenomenological_Enquiry_and_Psychological_Research_in_Caring_and_Quality_of_Life_Contexts_Acknowledging_the_Invisible

Sloan, A., & Bowe, B. (2015). Experiences of computer science curriculum design: A phenomenological study. *Interchange, 46*(2), 121-142. doi:10.1007/s10780-015-9231-0

Snelgrove, S. R. (2014). Conducting qualitative longitudinal research using interpretative phenomenological analysis. *Nurse Researcher (2014+), 22*(1), 20. doi:10.7748/nr.22.1.20.e1277

Solon, G., Haider, S. J., & Wooldridge, J. M. (2015). What are we weighting for? *Journal of Human resources, 50*(2), 301-316. doi:10.3368/jhr.50.2.301

Sommers, B. D., Kenney, G. M., & Epstein, A. M. (2014). New evidence on the Affordable Care Act: coverage impacts of early Medicaid expansions. *Health Affairs, 33*(1), 78-87. doi:10.1377/hlthaff.2013.1087

Soo-Hoon, L., Phan, P. H., Dorman, T., Weaver, S. J., & Pronovost, P. J. (2016). Handoffs, safety culture, and practices: Evidence from the hospital survey on patient safety culture. *BMC Health Services Research, 16.* doi:10.1186/s12913-016-1502-7

Sorkin, D. H., Ngo-metzger, Q., & De Alba, I. (2010). Racial/Ethnic discrimination in health care: Impact on perceived quality of care. *Journal of General Internal*

Medicine, 25(5), 390-6. doi:10.1007/s11606-010-1257-5

Sprague, L., Afifi, R., Ayala, G., & Musah, L. E. (2019). Participatory praxis as an imperative for health-related stigma research. *BMC Medicine, 17* doi:10.1186/s12916-019-1263-3

Spaulding, S. (2015). Phenomenology of social cognition. *Erkenntnis, 80*(5), 1069-1089. doi:10.1007/s10670-014-9698-6

Speck, P. (2016). Culture and spirituality: Essential components of palliative care. *Postgraduate Medical Journal, 92*(1088), 341. doi:10.1136/postgradmedj-2015-133369

Stichler, J. F. (2016). Research, research-informed design, evidence-based design. *HERD: Health Environments Research & Design Journal, 10*(1), 7-12. doi:10.1177/1937586716665031

Stol, Y. H., Asscher, E. C. A., & Schermer, M. H. N. (2017). What is a good health check? An interview study of health check providers views and practices. *BMC Medical Ethics, 18*. doi:10.1186/s12910-017-0213-x

Surmiak, A. D. (2018). Confidentiality in qualitative research involving vulnerable participants: Researchers' perspectives. Forum: Qualitative Social Research, 19(3). doi:10.17169/fqs-19.3.3099

Suburban States. (2017). Population demographics for Stewart County, Georgia in 2017-2018. Retrieved from https://suburbanstates.org

Takyi, E. (2015). The challenge of involvement and detachment in participant observation. *The Qualitative Report, 20*(6), 864-872. Retrieved from

https://nsuworks.nova.edu/tqr/vol20/iss6/12/

Thabane, L., & Lancaster, G. (2017). Improving the efficiency of trials using innovative pilot designs: The next phase in the conduct and reporting of pilot and feasibility studies. *Pilot and Feasibility Studies, 4*. doi:10.1186/s40814-017-0159-2

Thomas, B. (2014). Health and health care disparities: the effect of social and environmental factors on individual and population health. *International Journal of Environmental Research and Public Health, 11*(7), 7492-7507. doi:10.3390/ijerph110707492

Thomas, T. L., DiClemente, R., & Snell, S. (2013). Overcoming the triad of rural health disparities: How local culture, lack of economic opportunity, and geographic location instigate health disparities. *Health Education Journal*, doi:10.1177/0017896912471049

Thomas, S. R., M.P.P., Holmes, G. M., Ph.D., & Pink, G. H., Ph.D. (2016). To what extent do community characteristics explain differences in closure among financially distressed rural hospitals? *Journal of Health Care for the Poor and Underserved, 27*(4), 194-203. doi:10.1353/hpu.2016.0176

Thomson, L. (2016). Negotiating identity: Symbolic interactionist approaches to social identity. *Canadian Journal of Sociology (Online), 41*(3), 433-436. doi: http://dx.doi.org/10.29173/cjs28185

Tipirneni, R., Rhodes, K. V., Hayward, R. A., Lichtenstein, R. L., Reamer, E. N., & Davis, M. M. (2015). Primary care appointment availability for new Medicaid patients increased after Medicaid expansion in Michigan. *Health Affairs, 34*(8),

1399-1406N. doi:10.1377/hlthaff.2014.1425

Toews, L. C., M.L.I.S. (2017). Compliance of systematic reviews in veterinary journals with preferred reporting items for systematic reviews and meta-analysis (PRISMA) literature search reporting guidelines. *Journal of the Medical Library Association, 105*(3), 233-239. doi:10.5195/jmla.2017.246

Truong, M., Gibbs, L., Paradies, Y., & Priest, N. (2017). "Just treat everybody with respect": Health service providers' perspectives on the role of cultural competence in community health service provision. *ABNF Journal, 28*(2), 34-43. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/central/docview/1923971491/fulltextPDF/7A11D449C6E644BDPQ/1?accountid=14872

Tuohy, D., Cooney, A., Dowling, M., Murphy, K., & Sixsmith, J. (2013). An overview of interpretive phenomenology as a research methodology. *Nurse Researcher, 20*(6), 17-20. doi:10.7748/nr2013.07.20.6.17.e315

U.S. Census Bureau (2015). Quick facts Georgia. Retrieved from http://www.census.gov/quickfacts/table/AGE775215/13

U.S. healthcare: plumbing the depths of disparities. (2016). *Lancet (London, England), 387*(10031), 1879. doi:10.1016/S0140-6736(16)30453-6

Usha, V. K., & Lalitha, K. (2016). Quality of life of senior citizens: A rural-urban comparison. *Indian Journal of Social Psychiatry*, *32*(2), 158. doi:10.4103/0971-9962.181104

Vandenbroucke, J. P., & Pearce, N. (2018). From ideas to studies: How to get ideas and

sharpen them into research questions. *Clinical Epidemiology, 10*, 253-264. doi:10.2147/CLEP.S142940

Van Regenmortel, S., De Donder, L., Dury, S., Smetcoren, A., De Witte, N., & Verté, D. (2016). Social exclusion in later life: A systematic review of the literature. *Journal of Population Ageing, 9*(4), 315-344. doi:10.1007/s12062-016-9145-3

Vergunst, R., Swartz, L., Mji, G., MacLachlan, M., & Mannan, H. (2015). 'You must carry your wheelchair' - barriers to accessing healthcare in a South African rural area. *Global Health Action, eight*. doi:10.3402/gha.v8.29003

Victorino, L., Field, J. M., Buell, R. W., Dixon, M. J., Susan, M. G., Menor, L. J., Pullman, M., Roth, A., Enrico, S., Jie, Z., (2018). Service operations: What have we learned? *Journal of Service Management, 29*(1), 39-54. doi:10.1108/JOSM-08-2017-0192

Viechtbauer, W., Smits, L., Kotz, D., Budé, L., Spigt, M., Serroyen, J., & Crutzen, R. (2015). A simple formula for the calculation of sample size in pilot studies. *Journal of Clinical Epidemiology, 68*(11), 1375-1379. doi:10.1016/j.jclinepi.2015.04.014

Wake, R. M. (2018). Unspoken barriers: An autoethnographic study of frustration, resistance and resilience. *The Qualitative Report, 23*(12), 2899. Retrieved from https://nsuworks.nova.edu/tqr/vol23/iss12/1

Walker, K. O., Clarke, R., Ryan, G., & Brown, A. F. (2011). Effect of closure of a local safety net hospital on primary care physicians' perceptions of their role in patient care. *The Annals of Family Medicine, 9*(6), 496-503. doi:10.1370/afm.1317

Waller, A., Dodd, N., Tattersall, M., Balakrishnan, N., & Fisher, R. (2017).Improving hospital based end of life care processes and outcomes: A systematic review of research output, quality, and effectiveness. *BMC Palliative Care, 16*. doi:10.1186/s12904-017-0204

Wang, H. E., Mann, N. C., Jacobson, K. E., Mears, G., Smyrski, K., & Yealy, D. M. (2013). National characteristics of emergency medical services responses in the United States. Prehospital emergency care, 17(1). doi:10.3109/10903127.2012.722178

Ward, H., Gum, L., Attrill, S., Bramwell, D., Lindemann, I., Lawn, S., & Sweet, L. (2017). Educating for interprofessional practice: moving from knowing to being, is it the final piece of the puzzle?. *BMC medical education*, *17*(1), 5. doi:10.1186/s12909-016-0844-5

Watson, F. A. (2016). Lessons learned on approaches to data collection and analysis from a pilot study. *Nurse Researcher (2014+), 24*(1), 32. doi:10.7748/nr.2016.e144

Weller, S. C., Vickers, B., Russel Bernard, H., Blackburn, A. M., Borgatti, S., Gravlee, C. C., & Johnson, J. C. (2018). Open-ended interview questions and saturation. *PLoS One, 13*(6). doi:10.1371/journal.pone.0198606

Wen, H., Borders, T. F., & Druss, B. G. (2016). Number of Medicaid prescriptions grew, drug spending was steady in Medicaid expansion states. *Health Affairs, 35*(9), 1604-1607,1-4. doi:10.1377/hlthaff.2015.1530

When financially vulnerable rural hospitals become critical access hospitals, patient safety improves in several areas. (2009). *MEDSURG Nursing*, *18*(5), 307.

doi:10.1037/e459452008-002

White, K., Haas, J. S., & Williams, D. R. (2012). Elucidating the role of place in health care disparities: the example of racial/ethnic residential segregation. Health services research, 47(3), 1278-1299. doi:10.1111/j.1475-6773.2012.01410.x

Wills, M. J., Whitman, M. V., & English, T. M. (2017). Travel distance to cancer treatment facilities in the deep south. *Journal of Healthcare Management, 62*(1), 30-43. doi:10.1097/00115514-201701000-00007

Wilson, A. (2015). A guide to phenomenological research. *Nursing Standard (2014+), 29*(34), 38. doi:10.7748/ns.29.34.38.e8821

Woith, W. M., Jenkins, S. H., Astroth, K. S., & Kennedy, J. A. (2014). Lessons learned from conducting qualitative research in a hospital. *Nurse Researcher (2014+), 22*(2), 40. doi:10.7748/nr.22.2.40.e1280

Wolgemuth, J. R., Erdil-Moody, Z., Opsal, T., Cross, J. E., Kaanta, T., Dickmann, E. M., & Colomer, S. (2015). Participants' experiences of the qualitative interview: Considering the importance of research paradigms. *Qualitative research, 15*(3), 351-372. doi:10.1177/1468794114524222

World Health Organization. (2019). Hospitals: Typology. Retrieved from https://www.who.int/hospitals/en/

Wray, J., Archibong, U., & Walton, S. (2017). Why undertake a pilot in a qualitative Ph.D. study? Lessons learned to promote success. *Nurse Researcher*, *24*(3), 31-35. doi:10.7748/nr.2017.e1416

Yamada, T., Chen, C. C., Murata, C., Hirai, H., Ojima, T., Kondo, K., Harris, J., (2015).

Access disparity and health inequality of the elderly: Unmet needs and delayed healthcare. *International Journal of Environmental Research and Public Health, 12*(2), 1745-1772. doi:10.3390/ijerph120201745

Yen, I. H., & Anderson, L. A. (2012). Built environment and mobility of older adults: Important policy and practice efforts. *Journal of the American Geriatrics Society, 60*(5), 951-956. doi:10.1111/j.1532-5415.2012.03949.x

Yingwattanakul, P., & Moschis, G. P. (2017). Life course perspectives on the onset and continuity of preventive healthcare behaviors. *Journal of Primary Prevention, 38*(5), 537-550. doi:10.1007/s10935-017-0482-7

Yoon, K., & Lee, M. (2018). Perception of community on attachment and resilience according to closing of hospitals. *Journal of Community Health, 43*(3), 586-597. doi:10.1007/s10900-017-0456-y

Zarsky, T. Z. (2014). Understanding discrimination in the scored society. *Washington Law Review*, *89*, 1375. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2550248

Zhang, X., Dupre, M. E., Qiu, L., Zhou, W., Zhao, Y., & Gu, D. (2017). Urban-rural differences in the association between access to healthcare and health outcomes among older adults in China. *BMC Geriatrics, 17*. doi:10.1186/s12877-017-0538-9

Zimmermann, K., Carnahan, L., Paulsey, E., & Molina, Y. (2016). Healthcare eligibility and availability and healthcare reform: Are we addressing rural women's barriers to accessing care?. *Journal of health care for the poor and underserved*, *27*(4A),

204. doi:10.1353/hpu.2016.0177

Appendix A: Interview Questions

Sometimes a way to learn about what a person has experienced and the changes associated with those experiences is to start from the beginning. We can now review the chart previously sent if the chart is complete. If the chart is not complete, that is fine we can work on it together. The purpose of the chart is to help remind people of events or experiences that were important in their life. At times there will be questions seeking some other detail about specific things mentioned in this interview. There will be no pressure, nor coercion for answers, so feel free to answer accordingly.

Interview Questions

1. Will you tell me more about yourself?
2. Can you describe the type of medical condition you were treated for before the hospital closure in your town?
3. Can you describe how you first became aware of the hospital closure in your town?
4. How do you see yourself today, regarding receiving urgent care for your medical condition?
5. Can you describe any particularly stressful or traumatic experiences that you have experienced as it relates to the hospital closure in your town?
6. What changes have you encountered as it relates to receiving medical treatment if it becomes necessary?
7. What, if anything, would you change about the hospital closures occurring in your town?

8. Did your family or friends become involved in helping you reach another medical facility further from where you reside if it becomes medically needed?
9. Can you describe the reliableness of the emergency medical services (EMS) transport units in your town?

Interview questions adapted from the work of Rowley, 2014.

Appendix B: Life Course Review Chart

Aspect of Your Life	Past	Present	Future
Family			
Friends			
Education			
Career			
Travel			
Financial Security			
Health Care Treatments Options			
Medical Conditions			

Note. Life course development for African American residents 65 years of age and older living in Stewart and Webster County after hospital closures occurred. Adapted from the work of Marcia (1966) and Worthman and Panter-Brick (1999).

Appendix C: Responses to Interview Questions

Table C1
Pilot Study Research Responses

Questions	Negative Responses	Positive Responses
2, 4, 5, 6, 8	4	0
3, 7, 9	3	1

Questions	Standard Error	Standard Deviation
2, 4, 5, 6, 8	2	2.83
3, 7, 9	1	1.41

Table C2
Negative Response Results to Questions 2, 4, 5, 6, 8

Sample Standard Deviation, s	2.8284271247462
Variance (Sample Standard), s2	8
Population Standard Deviation, σ	2
Variance (Population Standard), σ2	4
Total Numbers, N	2
Sum:	4
Mean (Average):	2
Standard Error of the Mean (SE$\bar{x}$):	2

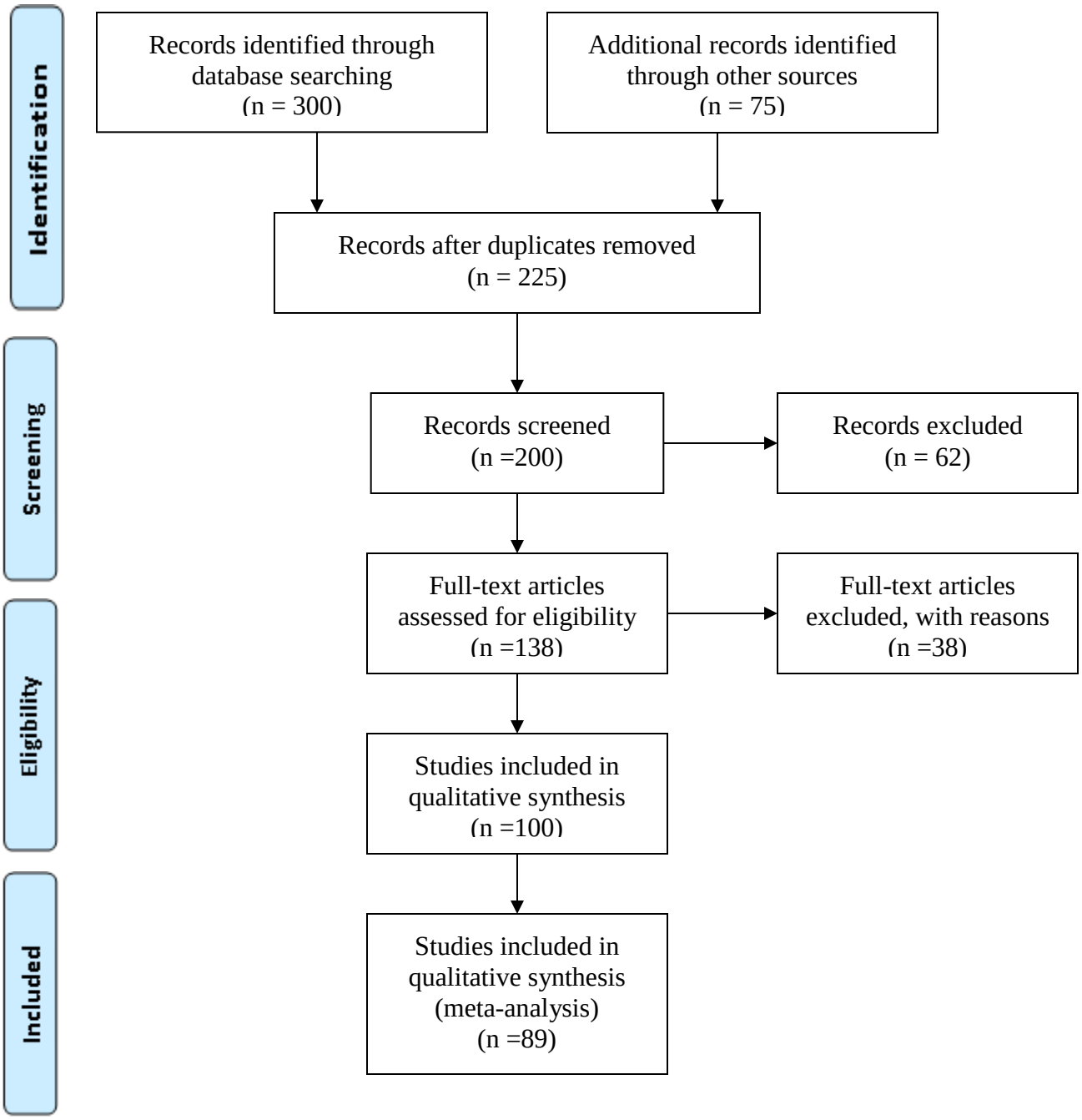
Table C3
Negative Response Results to Questions 3, 7, 9

Sample Standard Deviation, s	1.4142135623731
Variance (Sample Standard), s2	2
Population Standard Deviation, σ	1
Variance (Population Standard), σ2	1
Total Numbers, N	2
Sum:	4
Mean (Average):	2
Standard Error of the Mean (SE$\bar{x}$):	1

Table C4
Frequencies of Responses and Medians

Question	Sample Size	Negative Responses	%	Median Response	Positive Responses	%
2.	8	4	7.55	50	4	7.55
3.	8	4	7.55	50	4	7.55
4.	8	6	11	75	2	3.8
5.	8	7	13	87.5	1	1.9
6.	8	7	13	87.5	1	1.9
7.	8	6	11	75	2	3.8
8.	8	5	9.4	62.5	3	5.7
9.	8	4	7.55	50	4	7.55

Appendix D: PRISMA Flow Chart



Note. PRISMA Flow Diagram adapted from the work of Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009).