6-15-2016

Georgia's Rural Hospital Closures: The Common-Good Approach to Ethical Decision-Making

Randi G. Bastain
Georgia Southern University

Marcus Garner
Georgia Southern University

John S. Barron
Georgia Southern University, jb14662@georgiasouthern.edu

Emmanuel A. Akowuah
Georgia Southern University, ea01286@georgiasouthern.edu

William A. Mase
Georgia Southern University, wmase@georgiasouthern.edu

LITERATURE REVIEW

Georgia's rural hospital closures: The common-good approach to ethical decision-making

Randi G. Bastian, MPH, Marcus Garner, MPPA, John S. Barron, MPH, Emmanuel A. Akowuah, MS, and William A. Mase, DrPH

Jiann-Ping Hsu College of Public Health, Department of Health Policy and Management, Georgia Southern University, Statesboro, GA

Corresponding Author: William A. Mase • PO Box 8015 Statesboro, GA 30460-8015 • (912) 478-6984 • wmase@georgiasouthern.edu

ABSTRACT

Background: Critical access hospitals provide several essential services to local communities. Along with the functions associated with providing necessary medical care, they also offer employment opportunities and other economic benefits to the communities they serve. Since 2010, the number of rural hospitals closures has steadily increased. The common-good approach to ethical decision-making provides a framework that aids in evaluation of the effects that hospital closures have on rural residents and communities.

Methods: This analysis includes results of a systematic overview of peer-reviewed literature to address the following research questions: 1) How have state policies and the adoption of Medicaid expansion influenced the viability or rural hospitals? 2) What are the ethical implications of Medicaid expansion and state policy reform/adoption pertaining to viability of rural hospitals? and 3) What are the ethical implications of critical access hospitals closures on rural communities in Georgia? Information related to these questions is presented, along with tactics to addressing these in an ethical manner.

Results: This descriptive analysis shows that the largest number of state-specific closures have occurred in states with a federal exchange and which chose not to expand Medicaid. Characteristics of the state of Georgia and the counties with recent closures show that these counties typically have smaller populations with a high minority presence, lower education and income levels, and higher numbers of medically uninsured.

Conclusions: The common-good approach to ethical decision-making is suitable for evaluating the ethical implications of policy-level decisions impacting the closure of critical access hospitals serving the rural communities of Georgia.

Key Words: rural hospital, critical access hospital, ethics, hospital closures, common-good

doi: 10.21663/jgpha.5.417

INTRODUCTION

In the United States, hospitals have, for centuries, been involved in delivery of health care. Hospitals provide resources and services when people experience the birth of a child or the death of a loved one, and when they receive treatments for various diseases (DeGeeter, 2009).

For rural communities, critical access hospitals (CAHs) serve as the first line of defense in response to health-related medical emergencies (House, 2007). In rural areas, rural hospitals are often one of the largest employers and make substantial economic contributions (Doeksen et al., 1992; Doeksen et al., 1998; Willis et al., 2015). In a rural community, the construction of a hospital creates jobs, boosting the economy (Doeksen et al., 2012). In contrast, the closure of a rural hospital often results in a decline in the local economy (Doeksen et al., 1990). Thus, health care providers and executives, politicians, and public health practitioners should address the ethical influences of these choices being imposed upon Georgia's rural communities.

Since 2010, there has been an increase in the rate of closures of rural hospitals (Countouris et al., 2014; Jaffe, 2015; Kaufman et al., 2016). Closure of these hospitals is more likely to create negative health risks and economic hardships on rural residents compared to urban residents. This is concerning, since rural residents, as compared to urban residents, are typically poorer, older, present with worse health conditions and are more dependent on governmental health care insurance programs (Newkirk & Damico, 2014).

In 2012, there were, in the U.S., 5,723 registered hospitals, which housed 920,829 hospital beds and encompassed 36,156,245 admissions (American Hospital Association, 2014). In 2013, there were 5,686 registered hospitals, which housed 914,513 hospital beds along with 35,416,020 admissions (American Hospital Association, 2015). More recently, in 2014 there were only 5,627 registered hospitals in the U.S., housing 902,202 hospital beds with 34,878,887 total admissions (American Hospital Association, 2016).

These data show over the three-year period, a decrease in the number of registered hospitals. The acceleration of rural hospital closures and the concern for the rural residents have heightened the interest of researchers to search for the causes and find solutions to these issues.

In 1997, the Medicare Rural Hospital Flexibility Program (Flex Program) was implemented to address the concerns about financial growth of small rural hospitals (Kaufman et al., 2016). To sustain these small rural hospitals, the Flex Program paid, on a reasonable cost basis for the inpatient and outpatient services of hospitals that designated their facilities as CAHs (Kaufman et al., 2016). In the early 2000s, the Flex Program prevented many rural hospitals from closing (Liu et al., 2011). However, after implementation of the Patient Protection and Affordable Care Act (ACA) in 2010, there was an increase in the rate of closures of rural hospitals. Although other factors contributed, the ACA is considered to be the main cause of these closures (Holmes, 2015). The ACA enforced baseline access to insurance coverage and imposed regulations related to reporting requirements, reimbursement, and penalties for noncompliance (Abrams, 2016). States were given the option to create and manage their own health care exchanges or to implement the federal exchange (Carpenter, 2013; DeMichele, 2015). Expansion of Medicaid, a controversial topic that began as a federal government mandate, is now an option for states to utilize without being deemed non-compliant (Henry J. Kaiser Family Foundation (KFF), 2012).

Health care changes after 2010 highlight the importance of ethical decision-making for states concerning their hospitals and the communities they serve. The Markkula Center for Applied Ethics describes five approaches for dealing with moral issues such as hospital closures (Velasquez et al., 2014). The common-good approach assumes that the good of individuals is linked to that of the community and that the community is linked to its members through mutual values and goals that broadcast social services to all within the community (Velasquez et al., 2014).

The present analysis aims to illuminate the ethical implications brought forth by state policy reform and adoption of Medicaid expansion. Factors influencing viability of rural hospitals, the ethical issues affecting closures of hospitals in Georgia, and the consequences for communities served by these CAHs are presented.

METHODS

A systematic review of peer-reviewed literature was conducted to address the following research questions: 1) How have state policy reform and adoption of Medicaid expansion influenced viability of rural hospitals? 2) What are the ethical implications of Medicaid expansion and state policy reform/adoption pertaining to viability of rural hospitals? and 3) What are the ethical implications of CAH closures on rural communities in Georgia? Georgia Southern University's Office of Research and Sponsored Programs Human Subject Review Board approved this research under IRB H16330.

Prior to exploring ethical implications, the Rural Hospital Closures: 68 Closures from January 2010-Present produced by the North Carolina Rural Health Research Program (2016) were used to identify the hospital-specific breakdown for type of Medicare payment. States with hospital closures between January 2010 and February 2016 were selected to review both the policy reform and adoption and Medicaid expansion information provided by the Henry J. Kaiser Family Foundation. States examined included: Alabama, Arizona, California, Georgia, Illinois, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, and Wisconsin. State policy reform and adoption were dichotomously categorized (Federal=0; State=1). Medicaid expansion was categorized into expanded, expansion under discussion, and not expanding at this time.

Databases searched included CINAHL, Medline, ScienceDirect, and PubMed. The following Boolean search syntax were used: "rural hospital AND closures," "rural hospital AND sustainability," "ethical approach AND hospital closure," and "Medicaid AND rural hospital closures." The results were filtered to include only peer-reviewed documents published in academic journals from 2010 to the present in settings within the US. Only articles available in English were included. Additionally, this review focused on the categorization of state policy reform, including state Medicaid expansion. The literature available on rural hospitals and their capacity to survive in the selected states was assessed based on their policy decisions. Hospital closures in Georgia were flagged in hospital typology due to higher numbers of CAH closures than in other states. Census data on the Georgia counties with closures provides descriptive statistics and an understanding of the communities affected by the changes.

Of the five ethical approaches, the common-good approach from the Markkula Center for Applied Ethics was used to examine community economy and accessibility (Velasquez et al., 2014). Although there is concern for the negative effects patients and communities throughout the U.S. are experiencing, hospital closures continue at higher rates than in previous years (National Rural Health Association, 2016).

RESULTS

According to the Kaiser Family Foundation, 32 states have expanded Medicaid, 16 do not plan to expand, and 3 are considering expansion but have not chosen to do so at this time (KFF, 2014). Of the states with hospital closures after January 2010, 10 of 25 had legislators decide on expanding state Medicaid (North Carolina Rural Health Research Program (NCRHRP), 2016; KFF, 2014). Table 1 shows the breakdown of states with Federal Exchange and No Medicaid Expansion, Federal Exchange and Medicaid Expansion Under Discussion, Federal Exchange and

Medicaid, and State Exchange and Medicaid. The numbers in parentheses show hospital closures in that state since January 2010. All states that adopted a state exchange also chose to expand Medicaid. The hospital typology based on the type of Medicare payment derived from the North Carolina Rural Health Research Program was broken down based on the state Medicaid decision and the number of hospital closures. This information (Table 2) shows that the highest numbers of closures occurred in states without a decision to expand Medicaid. Specifically, CAHs and Prospective Payment System typology hold the highest closures, 16 and 19, respectively. The largest numbers of state-specific closures are in the federal exchange and non-expanded Medicaid locations. Table 3 shows the CAH closures by states with a Federal exchange and a decision to decline expansion of Medicaid. The highest within this breakdown is the state of Georgia. Of Georgia's five hospital closures since 2010, four were CAHs. Thus, it appears that Georgia's rurality has a negative influence on sustainability of rural hospitals.

Table 1. Hospital closures and state breakdowns by exchange type and Medicaid decision

Federal Exchange and no Medicaid Expansion	Federal Exchange and Medicaid Expansion Under Discussion	Federal Exchange and Medicaid	State Exchange and Medicaid
Alabama (5) Georgia (5) Kansas (2) Maine (3) Mississippi (4) Missouri (2) Nebraska (1) North Carolina (3) Oklahoma (2) South Carolina (4) Tennessee (6) Texas (10) Wisconsin (1)	South Dakota (1) Virginia (1)	Arizona (3) Nevada (1) Ohio (2) Pennsylvania (2)	California (3) Illinois (1) Kentucky (2) Massachusetts (1) Michigan (1) Minnesota (2)
Total Closures = 48 (70.6%)	Total Closures = 2 (2.9%)	Total Closures = 8 (11.8%)	Total Closures = 10 (14.7%)

Numbers in parentheses by state names show hospital closures in states since January 2010.

Hospital typology shows the breakdown of state Medicaid expansion decisions in relation to the payment-determined typology of the closed hospital (Table 2). With regard to the 24 CAHs that have closed, two-thirds are located in states that chose not to expand their Medicaid programs at this time.

Table 2. Hospital typology

Medicaid Expansion Decision	Typology	Closures
Not adopting at this time	CAH	16
Adopted	CAH	8
Not adopting at this time	DSH	1
Not adopting at this time	MDH	8
Adoption under discussion	MDH	1
Adopted	MDH	1
Not adopting at this time	PPS	19
Adopted	PPS	8
Not adopting at this time	Re-based SCH	1
Adoption under discussion	Re-based SCH	1
Not adopting at this time	RRC	1
Not adopting at this time	SCH	2
Adopted	SCH	1
	TOTAL	**68**

Abbreviations: CAH, critical access hospital; DSH, disproportionate share hospital; MDH, Medicare dependent hospital; PPS, prospective payment system; Re-based SCH, re-based sole community hospital; RRC, rural referral center; SCH, sole community hospital.

Since 2010, 48 hospitals have closed in states that implemented a federal health exchange without a Medicaid expansion (Table 3). From these states, most in the southern U.S., Georgia had four of five closures within the CAH designation.

Table 3. Hospital closures CAHs

Federal Exchanges with no Medicaid Expansion	Number of Closures	Number of CAHs
Alabama	5	1
Georgia	5	**4**
Kansas	2	0
Maine	3	1
Mississippi	4	2
Missouri	2	0
Nebraska	1	1
North Carolina	3	3
Oklahoma	2	0
South Carolina	4	1
Tennessee	6	0
Texas	10	2
Wisconsin	1	1
TOTALS	**48**	**16**

Table 4 shows the five Georgia counties with hospital closures since 2010, their demographics and the demographics for Georgia. Hart County had a Medicare Dependent Hospital (MDH) closure; Stewart, Calhoun, Charlton, and Wheeler Counties experienced CAH closures (NCRHRP, 2016). All these counties have greater percentages of adults 65 years of age and older relative to the state average. The counties with CAH closures all have populations less than 13,000, higher percentages of individuals self-identified as Black or African American, lower than state average percentages of individuals with a high school education or higher, higher percentage of uninsured, and lower income levels and higher poverty percentages than the state averages (Census Bureau n.d.).

Table 4. Demographics of Georgia counties with hospital closures since 2010

Demographics 2014 estimates	Hart	Stewart	Calhoun	Charlton	Wheeler	Georgia
Population						
Population	25377	5744	6463	12897	7995	10097343
Age and Sex						
Persons under 5 yrs., %	5.5	4.4	4.8	5.6	4.3	6.6
Persons under 18 yrs., %	21.4	15.4	19.0	19.0	16.9	24.7
Persons 65 yrs. and over, %	20.6	15.3	12.5	13.3	12.8	12.4
Female persons, %	50.4	38.9	40.0	39.7	34.8	51.2
Race and Hispanic origin						
White, %	78.4	45.1	36.1	65.0	60.2	62.1
Black/African American, %	18.8	51.5	61.2	32.0	38.4	31.5
American Indian and Alaska Native, %	0.2	0.6	0.6	0.6	0.2	0.5
Asian, %	1.0	1.0	0.6	0.6	0.3	3.8
Two or more races, %	1.5	1.7	1.3	1.8	0.9	2.0
Hispanic or Latino, %	3.6	24.5	4.7	3.5	5.4	9.3
Education						
2010-2014, ≥high school graduate, % persons >25 yrs.	80.8	61.9	68.3	75.6	73.1	85.0
2010-2014, ≥Bachelor's degree, % of persons >25 yrs.	14.6	9.7	9.4	11.4	8.1	28.3

Demographics 2014 estimates	Hart	Stewart	Calhoun	Charlton	Wheeler	Georgia
Health						
Persons without health insurance, < 65 years, %	20.8	21.5	23.7	19.9	22.8	17.9
Income and Poverty						
Median household income (in 2014 dollars), 2010-2014	36867	21880	26309	41059	27629	49342
Persons in poverty, %	21.4	39.4	38.5	29.5	38.9	18.3

Data retrieved from Census Quick Facts

DISCUSSION

The Center for Medicare & Medicaid Services (CMS) describes a CAH as a hospital certified to receive cost-based Medicare payments in a way different from that for an acute-care hospital (2014). A CAH has no more than 25 inpatient beds; no more than a 96-hour length of stay; offers 24-7 emergency care; and is located in a rural area at least 35 miles from another hospital.

Based on information provided above, rural hospitals, specifically CAHs, are seemingly vulnerable for future closure. Most of the population they serve, older adults and low-income residents, have greater dependency on Medicare and Medicaid. The CAH reimbursement efforts were to enhance financial outcomes that were losing resources, and consequently to reduce closures (CMS, 2014). Efforts were made to deal with income reductions experienced following increases in the numbers of uninsured and Medicaid-dependent patients. Through the ACA, these disproportionate numbers were expected to decline due to acquisition of insurance coverage or enrolling in Medicaid. Legislators anticipated that states would implement a Medicaid expansion program to reduce hospital financial burdens. Many states, however, did not adopt this policy. This lack of adoption appears to be associated with the higher numbers of rural hospital closures in states without Medicaid expansion.

Four of the five hospitals closing in Georgia were CAHs. In rural areas of Georgia, a lack of providers, lower reimbursements, lower incomes, and high numbers of chronic illnesses are negative factors influencing hospital sustainability (KFF, 2014). Georgia's established health care policies are tailored to serving the urban core (KFF, 2014), but the state has a disproportionate number of rural communities. The CMS has based their reimbursements on this tactic as well (KFF, 2014). Therefore, hospitals serving rural communities with disproportionately higher numbers of residents living in poverty and greater proportions of residents suffering from advanced health issues are adversely affected, with hospitals receiving less funds to provide healthcare services.

The common-good approach relates to the Medicaid expansion policies and other factors contributing to hospital closures and reflects the initial definition that states, all individuals are part of a larger community (Velasquez et al., 2014). Opinions of state and local policymakers influence the welfare of others within a community. This approach is based on actions taken to assist and protect the good of all, including the most underserved populations, in order to sustain society and communities (Velasquez et al., 2014). With this approach, an accessible and affordable health care system would promote a nurturing and functioning community. Nevertheless, barriers may hamper the "common good development" within the community due to diverse yet distinctive perspectives of what constitutes "the common good for individuals" (Velasquez et al., 2014). However, a health care delivery system based upon supporting the most vulnerable, the elderly, women, racial/ethnic minorities, and residents living in poverty within the areas suffering most from hospital closures in Georgia would be a different approach.

Further, persistent factors, such as inadequate reimbursement systems, lack of providers, uninsured and underinsured populations, and rural locations will likely lead to more closures in the future. The question remains as to whether the fiscal reimbursement issues of the health care systems within Georgia's communities served by CAHs will be addressed through development of intentional and responsive health care policies. If not, Georgia will likely continue to see these vulnerable communities suffer from the erosion of the system for delivery of health care. Most of the hospitals experiencing closures serve aging populations and populations with high poverty rates. If these hospitals are not supported by payment systems that attend to those most vulnerable financially, loss of providers and quality improvement, financial hardships, and closures will likely continue.

Hospitals did not begin as a public service for the common good, but the evolution of health care and access to insurance are amplifying the necessity to establish a commonality between community and health services. Future studies should identify alternatives for hospital closures. This process would begin by exploring creative models that demonstrate a rebranding of services within communities to change the perception of local health care. Instead of closures, linking resources of existing local health care services and health care facilities may lead to strategies for sustaining communities instead of focusing on sustaining the hospitals. Further research is needed to create innovative rural healthcare delivery systems that respond to the maldistribution of health care resources. By responding

to Georgia's, as well as the nation's, current failures in healthcare policies, new health-related policies should reestablish and revitalize the healthcare system.

Most would agree that an affordable health system is part of a common good (Velasquez et al., 2014). However, hospitals continue to be denied resources to provide care and services within the community. This illustrates how individuals and entities can agree on values; however, they may disagree on the relative values set for a community (Velasquez et al., 2014). Consequently, they may perceive a need to shift investments to another system beyond health care. The common-good consists primarily of systems, environments, and institutions working cohesively to benefit the people (Velasquez et al., 2014). The following question needs to be answered. Are the emerging health care policies relating to reimbursement a demonstration of a society that is losing sight of a common good, health care for all members of the society?

Researchers should investigate the concept of establishing a system similar to the Federally Qualified Health Center (FQHC) program (Butler et al., 2007). FQHCs are safety-net health care facilities that are legislatively established based on the health care needs of communities (United States Department of Health and Human Services-Health Resources and Services Administration, n.d.). The FQHCs, which require quality and program measures to be accomplished before organizations receive federal resources, serve the primary health care needs of low-income working families and medically underserved, high-risk, and vulnerable populations. FQHCs foster partnerships among entities, such as emergency rooms, providers, structured transportation systems, and facilities, and sharing of electronic medical records (Butler et al., 2007).

Ethical issues arise in addressing investments in the community but denying funds for hospital viability. With funds decreasing, questions arise: 1) Does the life of the community or financial reimbursements come first? and 2) Are the closures of CAHs in Georgia actually closures of the communities they once served?

CONCLUSIONS

The increased rate of hospital closures is a threat to patient care and to local economic stability. The ethical implications associated with denying a rural, often minority, and historically impoverished population access to medical care must be considered as policy makers develop programs that can detrimentally affect rural hospitals (Newkirk and Damico, 2014). A central principle of the common-good approach is that the well-being of the individual is inexorably linked to the well-being of the community (Velasquez et al., 2014). As the individual benefits, so does the community. Data examined in this report suggest a link between those states opting out of Medicaid expansion and the increased number of closures of rural hospitals. The effects of these closures at the individual and community level must be determined by future research. Long-term measures of morbidity and mortality in communities experiencing a rural hospital closure will provide information for future investigators to determine the effects of today's political and economic decisions.

Current policy decisions must be evaluated in light of future ethical and financial implications. Accurate data will provide a basis upon which to make moral and ethical decisions. Data, however, should be used in a responsible, fair, and logical manner. Future researchers may choose to examine the effects of care provided by larger facilities located at greater distances compared to care provided at smaller, local facilities. Any observed effects could then be incorporated into examination of various ethical decision-making models and access to health care while addressing the community impact and potential stigma associated with delivery of rural health care services.

The ACA represents a recent and prominent policy related to health care access. Its effect on rural health care, Georgia being an example, should be determined with a focus incorporating ethical, economic, and quality-of-life indicators. When evaluating benefits to ACA implementation and hospital closures, recruiting medical providers to rural communities could address barriers, utilization of small-town hospitals, and providing transportation to medical facilities (Newkirk and Damico, 2014).

Without change, it is likely that rural hospitals will continue to close at an increasing rate, and rural communities will bear these burdens. The challenges created by these closures will affect people living in poverty, racial and ethnic minorities, and the elderly to a greater degree than the general population. These factors point to ethical concerns needing to be addressed. In a responsible society, the effect of community-level decisions on individual welfare should be evaluated.

Acknowledgements

A doctoral student research team conducted this research as part of the course requirements for PUBH 9331, Health Policy, Regulation and Ethics at the Jiann-Ping Hsu College of Public Health. The authors extend appreciation to Department of Health Policy and Management faculty mentors who are conducting transformational practice-based research throughout Georgia related to rural hospital sustainability and operations. A special thank you to Dr. William Mase for providing direction, guidance, and encouragement throughout the process.

References

Abrams, M. (2016, March 24). *Reverse rural hospital decline*. Retrieved from http://www.usnews.com/opinion/blogs/policy-dose/articles/2016-03-24/rural-hospitals-are-disappearing-after-obamacare-how-do-we-save-them

American Hospital Association. (2014). Fast facts on US hospitals. Retrieved from http://www.aha.org/research/rc/stat-studies/fast-facts2014.shtml.

American Hospital Association. (2015). Fast facts on US hospitals. Retrieved from http://www.aha.org/research/rc/stat-studies/fast-facts2015.shtml.

American Hospital Association. (2016). Fast facts on US hospitals. Retrieved from http://www.aha.org/research/rc/stat-studies/fast-facts.shtml

Butler, L., Fontanez, A., McKenzie, R., & Samuels, M. E. (2007). Developing rural federally qualified health center and critical access hospital collaboration in Appalachia: A demonstration project. Retrieved from http://www.ruralhealthweb.org/go/left/publications-and-news/resources

Carpenter, C.E. (2013). *State health insurance exchanges.* Retrieved from https://eds-b-ebscohost-com.libez.lib.georgiasouthern.edu/eds/pdfviewer/pdfviewer?sid=ae6d91a9-58a6-4286-a243-455f68ffda6f@sessionmgr110&vid=1&hid=104

Census Bureau. United States quick facts from the census bureau. Retrieved from www.census.gov/quickfacts

Center for Medicare & Medicaid Services (CMS). (2014). Critical access hospital: Rural health fact sheet series.

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

DeGeeter, M. (2009). ASID: The hospital's role in the community. Retrieved from http://www.healthcaredesignmagazine.com/blogs/mjdegeeter/asid-hospitals-role-community.

DeMichele, T. (2015). What is the health insurance marketplace? Retrieved from http://obamacarefacts.com/insurance-exchange/

Doeksen, G.A., Clair, C.F.S., & Eilrich, F.C. (2012). The economic impact of a critical access hospital on a rural community. *National Center for Rural Health Works.* Retrieved from http://ruralhealthworks.org/wp-content/files/Impact-of-CAH-Study-NEW-FORMAT-090712.pdf

Doeksen, G. A., Loewen, R. A., & Strawn, D. A. (1990). A rural hospital's impact on a community's economic health. *Journal of Rural Health, 6*(1), 53-64. doi:10.1111/j.1748-0361.1990.tb00190.x

Doeksen, G.A. Cordes, S, & Schaffer,R. (1992). Health care's contribution to rural economic development. Funded by Office of Rural Health Policy, DHHS, Health Resources and Services Administration.

Doeksen, G. A., Johnson, T., Biard-Holmes, D., & Schott, V. (1998). A healthy health sector is crucial for community economic development. *Journal of Rural Health, 14*(1), 66-72. doi:10.1111/j.1748-0361.1998.tb00864.x

Henry J. Kaiser Family Foundation (KFF). (2014). The Georgia health care landscape. Retrieved from http://kff.org/health-reform/fact-sheet/the-georgia-health-care-landscape/

Henry J. Kaiser Family Foundation (KFF). (2012). A guide to the Supreme Court's decision on the ACA's Medicaid expansion. Retrieved from https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8347.pdf

Holmes, M. (2015). Financially Fragile Rural Hospitals Mergers and Closures. North Carolina medical journal, 76(1), 37-40.

House, P. (2007). Community benefits of critical access hospitals in Washington. University of Washington, School of Medicine.

Jaffe, S. (2015). Aging in rural America. *Health Affairs, 34*(1), 7-10. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25561638

Kaufman, B.G., Thomas, S.R., Randolph, R.K., Perry, J.R., Thompson, K.W., Holmes, G.M., & Pink, G.H. (2016). The rising rate of rural hospital closures. *Journal of Rural Health, 32*(1), 35-43. doi:10.1111/jrh.12128

Liu, L., Jervis, K.J., Younis, M.Z., & Forgione, D.A. (2011). Hospital financial distress, recovery and closure: Managerial incentives and political costs. *Journal of Public Budgeting, Accounting & Financial Management,* 23(1), 31-68.

National Rural Health Association. (2015). Rural hospital closures are decimating rural health care delivery. Retrieved from: http://www.ruralhealthweb.org/index.cfm?objectid=E8ADA125-D6B1-9E89-0EC6AA08930E721F

Newkirk V. & Damico, A. (2014). The affordable care act and insurance coverage in rural areas.

North Carolina Rural Health Research Program (NCRHRP). (2016). *Rural hospital closures: 68 closures from January 2010-present.* Accessed February 20, 2016.

United States Department of Health and Human Services-Health Resources and Services Administration. What are federally qualified health centers (FQHCs)? (n.d.) Retrieved from http://www.hrsa.gov/healthit/toolbox/ruralhealthittoolbox/introduction/qualified.html

Velasquez, M., Andre, C., Shanks, S.J.T., & Meyer, M.J. (2014). The Common-Good. Retrieved from https://www.scu.edu/ethics/ethics-resources/ethical-decision-making/the-common-good/

Willis, L., Bishop, R., & Leatherman, J. (2015). The importance of the health care sector to the economy of Dickinson county. Kansas Hospital Association. Retrieved from: http://krhw.net/assets/docs/Economic%20Contribution%20Reports/Dickinson%20County%20Health%20Care%20Impact%20Report.pdf