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How Does Pay for Performance Pay Incentives Affect Long-Term Care

BIS 437: Senior Project

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Abstract

Quality of care is always an ever changing standard in healthcare including long-term care facilities. Assisted living facilities, short-term rehabilitation, and nursing home facilities can be classified under long-term care facilities. For the purpose of this paper, the focus will be on the impact of pay for performance pay incentives for nursing home facilities.

Research through previous, outside studies defines quality in regards to the different source standards. Residents and family members have different standards of quality care between themselves. States and federal regulations define their own definitions of quality care. A summary of quality standards is used to understand the expectations.

Nursing home funding doesn't always create a profit. This paper explores the funding resources for nursing homes. Since staffing wages will be determined by funding, licensure, and certifications, a nursing home has to understand their funding sources and market competition. A version of pay for performance pay incentive is a pay method used in Medicare reimbursement to hospitals and nursing homes. If we reimbursed our nursing home staff using the same method, how would this affect the nursing home facility? Past studies regarding pay for performance pay incentives will provide necessary data to demonstrate the effects on quality, funding/budgets, and staff response to the pay for performance pay incentives within the nursing home. By applying the data collected, recommendations and a concluding decision will be made regarding the effects of pay for performance pay incentives in the nursing home.

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How Does Pay For Performance Pay Incentives Affect Long-Term Care

Healthcare is an always changing environment. All healthcare facilities must maintain a level adaptation to the ever changing opinions, regulations, and market. One major challenge all healthcare facilities face is staffing requirements and quality of services rendered to the residents. Long-term care facilities are no exception to the staffing challenges faced in healthcare.

Long-term care facilities can be encompassed as assisted living facilities, short-term rehabilitation facilities, and nursing home facilities. The different types of facilities will be clarified later in this research paper. These facilities receive funding from a small variety of sources to face the ever changing healthcare environment.

Funding is received from private pay residents, managed care companies, Medicaid, and Medicare. Unfortunately, long-term care facilities struggle with funding from residents for various reasons; including the mix of those types of funding in the facility. This paper will provide details for different types of funding later in this research paper. No matter the funding situation, quality care must be rendered by the staff.

Quality of care, including the quality of life, given is measured differently depending on the source. Residents have their individual measure of quality of care, while their family members have a level of care that is often different than the resident. The state of which the facility is located has regulations to set standards of quality care. This research paper will provide a summary of the measure of quality in regards to the pay for performance pay incentives for the staff in long-term care facilities.

Staffing requirements for quality services are measured differently by the perspective of the source. The federal and state of which the facility is located has specific staffing

requirements. The facility or facility owner will have their own requirements. Residents and family members will have their opinion of the number of staffing needed to be provided to maintain the quality care. Staffing not only includes the number of staff available at a given time for care, but the quality of services rendered by each staff member.

By using the background and pay for performance pay incentive information, a researched decision and recommendations about how pay for performance pay incentives will affect long-term care facilities can be made. Staffing plays a major role in the success of quality care of long-term care. Just as quality care will measure the success of the long-term care facilities. The success of the pay for performance pay incentives can be measured by profits, staffing, and quality of care given or received.

Understanding Long-term Care Facilities

Assisted Living Facilities.

Assisted Living Facilities are recommended for senior-aged people who need some minor assistance performing daily living activities. These people are mostly independent and of strong mind. The residents of an assisted living facility live more of a normal life to what they were living at home and are considered to be living in an apartment within a community. Often, residents get to pick from multiple apartment layouts from studios to two bedroom suites.

All meals are provided for the residents ("Services and Amenities," 2018). These meals would be overseen by a registered dietician ("Services," 2019). Housekeeping services are provided for their individualized apartments, including trash removal. Residents do not have to worry about utility bills or basic television service ("Services and Amenities," 2018). The residents are welcome and encouraged to interact in the common areas and dining rooms.

Laundry isn't often a concern either with this service provided for the resident ("Services and Amenities," 2018). To add to the homelike experience and health benefits, some facilities allow residents to enjoy pets in their apartments ("Services," 2019). According to "Services and Amenities" (2018), security systems are on premises to aid in making the residential environment safe.

While the living style is more like an apartment, staff is located on site 24 hours a day, seven days a week for any needs the residents may have ("Services and Amenities," 2018; "Services," 2019). According to "Services" (2019), some staff are licensed and certified professionals to provide any medical assistance the residents may need. Emergency calls can be placed to an on-call system for emergency service ("Services and Amenities," 2018). Some facilities are equipped with an emergency alert system ("Services," 2019). All medical services are managed by a medical director ("Services," 2019).

Short-term Rehabilitation Center.

The short-term rehabilitation has people of all ages who need continued healthcare needs for a longer amount of time that is not a permanent service, but the person doesn't need to continue to stay in the hospital for these services. Some facilities will also refer to themselves as "transitional care"-a transition from hospital to home (Home, S., 2020). While these facilities offer services that are usually temporary, the patient is still receiving long-term care for a medical need. Often, services prescribed during short-term rehabilitation would include mobility and strength improvement, including physical therapy, occupational therapy, and speech therapy and skilled nursing services ("Move-In & Admissions," 2020).

According to "What is Physical Therapy" (2001), physical therapy is used to restore, provide maintenance, and promotion of physical function. People of all ages can encounter situations that may have hindered their abilities to perform certain functions. Short-term rehabilitation can provide an in-house stay while completing treatments. The physical therapists will be able to examine the condition and diagnose, provide a treatment plan and safe discharge to home plans ("What is Physical Therapy," 2001). Many residents' goals are to return home, and the physical therapist takes their goals into consideration when evaluating and creating a treatment plan for the resident. According to "What is Physical Therapy" (2001), physical therapists play an important role for the rehabilitation process for prevention, maintenance, and promoting health, wellness, and fitness. Sometimes, these services can continue to be provided when the patient is discharged to home. As with any medical facility, they would come back to the facility on an appointment basis to continue their therapy treatments and evaluations to continue care; this would be considered outpatient services.

Occupational therapy can be prescribed alone, in addition to and concurrently with physical therapy. According to Reed and Sanderson (2000), "Occupational therapy includes the study of human occupations in relation to personal health, life satisfactions, and sense of well-being and the management of the adaptive behavior or competent performance required to perform these occupations." While staying at a short-term rehabilitation center, the occupational therapist will be able to evaluate, provide a treatment plan with interventions and goals, and discharge plan. Occupational therapy helps the people achieve and adapt in their occupations (Reed & Sanderson, 2000). Senior patients need occupational therapy to create an independence for every day activities by treating their motor skills, extremity functions, and incontinence

(Parkview Nursing and Rehabilitation Center, 2020). Preventing dysfunctions and promoting maintenance is another purpose of the occupational therapy (Reed & Sanderson, 2000).

Speech therapy aids in the development of and interventions for speech from medical conditions and ability of your muscles to perform activities such as swallowing. According to Patino (2020), speech therapy aids in language interventions, articulations, as well as, feeding and swallowing. Most individuals first think of speech therapy as something a child receives to aid with pronouncing words and controlling their sounds. Speech therapy is used for all ages. As people age, a person might encounter deterioration of certain muscles and sensory processes or the deterioration may come from a medical event, such as a stroke. A speech therapist can evaluate, create a treatment plan with interventions, and a discharge plan for individuals. The speech therapist in a short-term rehabilitation center will treat patients who have trouble speaking and communicating with other residents and staff by helping aid them through the necessary avenues of communication. Some residents may need to be assessed for swallowing. The speech therapist will treat the patient while eating and make recommendations for a patient to safely eat in hopes they will be able to eat the foods they once loved.

Skilling nursing services is defined by the Administrative Code, 77 , Joint Committee on Administrative Rules 300.1230 § (a)(2), "skilled care is skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision." Skilled nursing services include care for wound care to diabetes management (Parkview Nursing and Rehabilitation Center, 2020). Care for patients after a variety of surgical procedures can be provided for infection management and wound care. Some facilities are able to provide IV therapy treatment, tube feeding assistance, colostomy assistance,

and vent assistance (Parkview Nursing and Rehabilitation Center, 2020). These patients need twenty-four hour, seven days a week nursing care.

During a patient's stay at a short-term rehabilitation facility, a patient can expect twenty-four hour security and nursing care. Private and semi-private rooms are available for recovery. All meals provided while being reviewed by a dietician. Housekeeping and laundry services are provided. Often facilities will provide transportation to and from appointments for healthcare needs. Daily activities throughout the day to stimulate activity and socialization. Ultimately, all medical services are provided by licensed and certified staff that are overseen by a medical director.

Nursing Home Facilities.

Nursing home facilities are trying to change their perspective in the surrounding communities by referring to themselves as "healthcare" or "long-term care" centers, or "skilled nursing facilities," instead of being called nursing homes. For the sake of this paper, these facilities will continue to be referred to as nursing homes.

These facilities provide a number of services to the patients that reside there. Residents will vary in the necessary level-of-care needed from the nursing staff. Some residents are mostly independent and would be well suited for the assisted living facilities, however, the residents or the family member(s) chose to move straight into the long-term care facility. These residents may need assistance with receiving their medications or other basic daily living functions.

Other residents are in need of more intermediate or custodial care. According to Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (a)(3), " Intermediate care is basic nursing care and other restorative services under periodic medical

direction." Intermediate care can include those residents who need a lot of assistance with daily living activities and can no longer live alone safely. The residents could need assistance with getting dressed, eating, going to the bathroom, properly taking medication, and transferring to and from a wheelchair or bed. The nursing home facilities will provide licensed and certified professionals to provide assistance to the residents for those tasks to prevent harm or injury to themselves. Medical professionals and activities are overseen by a medical director.

Nursing home residents can also be in need of skilled nursing services as covered above. Often, nursing home facilities have made a wing for short-term rehabilitation care and a separate wing for intermediate, long-term care residents. The resident may deteriorate from age or have a fall creating a need for further treatment or develop a medical condition, which could in turn create a need for skilled nursing procedure. By residing in a nursing home, all staff, especially nursing staff, will be able to monitor a resident's health closely. The frequent monitoring will increase the response time to conditions that may be onsetting. Nursing homes have procedures in place for staff to report any noticeable changes within the resident preventing the resident from worsening or even death. To aid in the process of health monitoring, most doctors will visit their patients that reside as residents in the nursing home facilities at least once a month up to two month intervals depending on their illness and payer requirements.

Most nursing homes provide the basic necessities for a resident's room. Often, these rooms are shared with other residents and joined by another room of two residents by a bathroom, but there are facilities able to provide private rooms. Residents can be provided with a bed, linens, furniture, television, and closet space ("FAQS," 2020). Meals are provided for the residents three times a day, along with snacks in between meals ("Amenities," 2020).

Housekeeping and laundry services are provided to residents. Residents have activities provided multiple times throughout the day, which they are encouraged to attend to maintain social cognition, physical activity, and maintain their motor skills. Residents are encouraged to bring personal items to create a more "home-like" experience ("FAQS," 2020). Of course, the amount and size of personal items are limited to what will keep the resident safe. Transportation is provided for residents that have non-emergency, routine medical appointments. If a resident is not independent, the nursing home requests family members to attend or may make arrangements for a certified staff member to attend the appointment to help aid the resident while out of the building.

Types of Funding Received by Long-Term Care Facilities

Many long-term care facilities accept payment for services through private pay, managed care organizations, Medicaid and Medicare. Long-term care facility rates can range from approximately $140 per day to $253 per day (Costs of Care, 2020), equally a range of approximately $4200 to $6750.00 monthly or approximately $81,000 annually. The cost of care depends which type of facility the resident is living in and does not include the charges for the range of extra services provided beyond intermediate or custodial care-for example, therapy services. While some residents are able to privately pay for the stay at a facility, other residents and families are left to rely on sources such as managed care organizations, Medicaid, and Medicare to help ease some of the burden. Managed care, Medicaid, and Medicare may be effective for easing the financial burden for residents; long-term care facilities can feel the effects of their payment reimbursement methods.

Private pay.

Private pay methods may sound obvious, however, there are different sources to obtain private pay funds. Private pay is where the resident pays for the room, services, and co-pays and deductibles directly out-of-pocket. Residents may earn enough money from their monthly income or savings to pay for the stay, while others may utilize the assets to produce enough funds to cover their out-of-pocket. Some of the assets may include reverse mortgages, annuities, and trusts (Paying Privately, 2020).

Reverse mortgages allow people to receive cash payments that will go against the value of the home, but allow the resident to keep possession of the home (Reverse Mortgage, 2020). Residents receive money in a lump sum, monthly payment, or to use as a line of credit towards anything they want without restrictions (Reverse Mortgage, 2020). The resident would be taking out a loan against their home. This would be an option for residents if they are staying in a short-term rehabilitation facility because the reverse mortgage doesn't have to be repaid until the resident moves out permanently or passes away (Reverse Mortgage, 2020). If the resident is a permanent long-term care resident in a nursing home, the reverse mortgage would not be effective because the reverse mortgage only allows patients to participate as long as the patient is still permanently residing in the home.

According to Longtermcare.gov (2020), the definition of annuity is:

> A contract in which an individual gives an insurance company money that is later distributed back to the person over time. Annuity contracts traditionally provide a guaranteed distribution of income over time, until the death of the person or persons named in the contract or until a final date, whichever comes first. (Glossary)

Annuities can be a great way to save and receive money over a period of time for long-term care services. Depending on the amount of money that may or may not have been saved, a resident may need additional funding options to cover the costs of healthcare services. A person would have to think of starting an annuity before the annuity is actually needed.

Trusts are established to manage assets and money of the resident. Trusts are managed by a designated trustee, set forth by the resident, to transfer funds from the asset and monies to the beneficiary, in this case would be the long-term care facility. Trusts need to be examined and set up by legal representatives (Trusts, 2020). Tax professionals should be allowed to advise on the trust because a trust can affect Medicaid eligibility if the need arises (Trusts, 2020).

Managed Care Organizations.

Many managed care organizations do not cover regular stay services. For managed care organizations to cover services, the services need to be a skilled nursing service or type of therapy services like those provided from Short-term Rehabilitation. Most managed care organizations follow the Medicare guidelines for requirements and reimbursement guidelines (What is Covered by Health and Disability Insurance?, 2020). Most organizations want a "qualifying" hospital stay (What is Covered by Health and Disability Insurance?, 2020). The hospital stay is specified in the resident's policy, which could vary from one night to three nights in the hospital. The managed care organization would require weekly or more frequent status assessments of the resident's progress. Like a regular consumer of services, the managed care organizations do not want to pay for services that are not needed and/or being provided.

These organizations can be classified into two models: fee-for-service and prepayment (Buchbinder & Shanks, 2017). Fee-for-service insurance is where the provider is paid by the

organization or the insured, then the insured will be reimbursed for services after any copayments or deductibles are met (Buchbinder & Shanks, 2017). Indemnity plans are based on the fee-for-service model (Buchbinder & Shanks, 2017). These plans do not cover a regular stay in long-term care facilities without an approved skilled service being provided.

Prepayment plans let the insurer pay a fixed amount set by the insurance company for services rendered and small co-payments (Buchbinder & Shanks, 2017). This allows the insurance companies to control the services, quality, and access (Buchbinder & Shanks, 2017). The types of plans included in the prepayment plan model are HMO's, PPO's, and POS.

HMO's are Health Maintenance Organizations (HMO) where services are used at no charge and very rarely require a copayment as long as the patients use a provider that contracts with the HMO (Buchbinder & Shanks, 2017). Not all long-term care facilities participate in HMO's or every HMO, this makes pre-approvals a necessity to prevent any extra or surprise out-of-pocket costs for the resident.

PPO's are Preferred Provider Organizations (PPO) that operate on a fee-for-service basis with providers in a the preferred network, but requires co-payments, deductibles, and co-insurances to be met (Buchbinder & Shanks, 2017). If a patient uses a long-term care facility for skilled services that is in network, the PPO will contract for a cheaper rate. If the long-term care facility is not a part of the network in a particular PPO, the insured could pay more out-of-pocket expenses.

POS plans, or Point-of-Service (POS), are plans that provide flexibility using the HMO model and are open-ended (Buchbinder & Shanks, 2017). This plan aids the insured with using services that would be considered not covered under an HMO by adding on copayments and

deductibles to the insured (Buchbinder & Shanks, 2017). The POS is a combination of HMO and PPO plans. Out-of-pocket costs are still a risk for the resident.

Medicare Supplemental Insurance organizations help pay the co-pays created from a qualifying Medicare stay (What is Covered by Health and Disability Insurance?, 2020). Usually, supplemental insurance doesn't need to be pre-authorized as long as Medicare is the primary payer. This type of insurance helps the resident potentially increase their time of care at the facility creating a quality treatment term. Like other types of insurance, supplemental insurance will not cover regular stay visits.

Medicaid and/or Managed Medicaid.

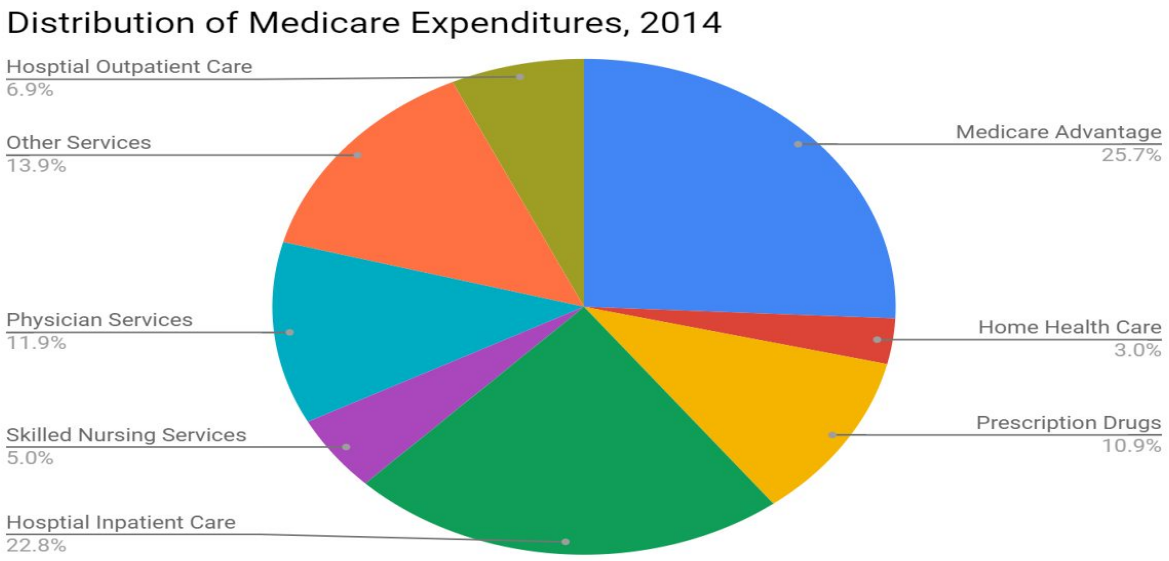
In short, Medicaid is government aid for low-income individuals and families. Medicaid is funded through state and federal resources to pay for some or up to all medical bills (State Medicaid Programs, 2020). Services covered by Medicaid at long term care facilities can include hospital costs, doctors visits, room and board, and services in facilities, including the basic stay of a resident (State Medicaid Programs, 2020). Like insurances, some state Medicaid programs are going to a Managed Medicaid system.

Managed Medicaid benefit recipients are reviewed for necessity before admission into a nursing home. Once admitted, Medicaid may ask for regular assessments for medical necessity to prevent paying for services that may or may not be needed. To determine how much care and what type of facility that is needed, most states base the necessity of services on the number of personal care and other services that the individual needs assistance with (State Medicaid Programs, 2020).

Medicare.

Medicare is a federal program for the elderly, individuals over the age of 65, that provides hospital and medical benefits to those meeting a specific criteria (Glossary, 2020). Medicare aids the elderly with healthcare with a four part plan: Part A, Part B, Part C, and Part D (Buchbinder & Shanks, 2017). Medicare does not cover basic services provided by long-term care facilities, such as nursing homes and assisted living facilities. Medicare does cover skilled nursing services that are provided by a Medicare certified short-term rehabilitation or nursing homes with short-term rehabilitation facility to the residents by Medicare Part A. According to Buchbinder & Shank (2017), in 2014 skilled nursing services accounted for five percent of Medicare expenses as shown in Figure 1.

Figure 1. (p. 223)



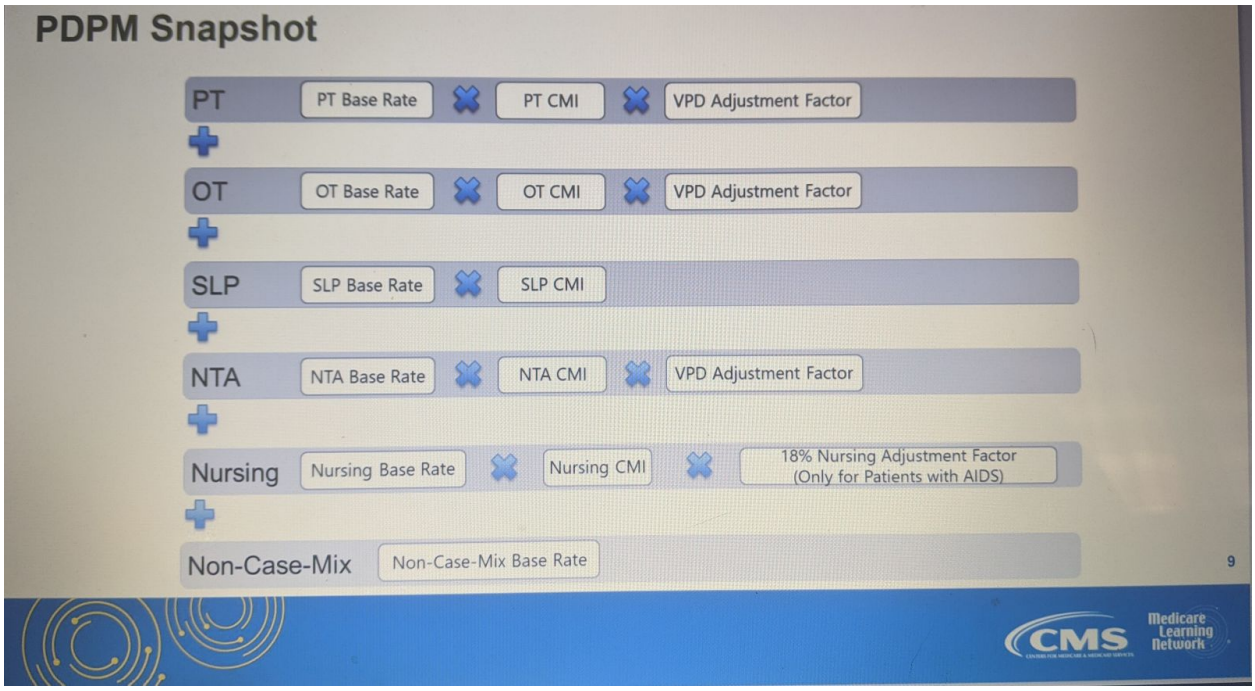
There are requirements to coverage qualifications. The resident has to have qualifying in-patient hospital stay of 3 days. When discharged, you must admit to a Medicare-certified facility within thirty days or less. The resident must participate in therapies or be willing for the facility to provide the skilled nursing care prescribed. Medicare requires an admission

assessment on day five of the Medicare stay. As long as the patient is actively participating in prescribed care and making progress, the resident may continue to be covered by Medicare.

Medicare will cover up to 100 days with Part A for skilled nursing services. Medicare will pay the full amount for the first twenty days. Starting on the twenty-first day, a co-pay of $176 per day starts being charged to the resident. The co-pay will continue to day one-hundred. Once the progress or the one-hundred days have been met, the resident will discharge back to home, assisted living facility, or nursing home. Medicare pays for services based on the Patient Driven Payment Model (PDPM) (SNF PPS: Patient Driven Payment Model).

PDPM improved the focus on the patient's needs versus the volume of services provided by the providers (SNF PPS: Patient Driven Payment Model). Previously, Medicare used RUGS-IV for payment reimbursement by paying a base rate for therapy or nursing services by the case-mix index. PDPM now classifies into Physical Therapy, Occupational Therapy, Speech Therapy, Nursing, and Non-Therapy Auxiliary (NTA) services (SNF PPS: Patient Driven Payment Model). The PDPM uses a base rate for each physical therapy, occupation therapy, and NTA services and limited nursing services variable by case-mix index by a variable per diem that varies over the stay as illustrated in Figure-2 (SNF PPS: Patient Driven Payment Model).

Figure-2



Issues with Managed Care Organizations, Medicaid, and Medicare.

Managed care organizations, Medicaid, and Medicare can hinder financial success for a long-term care facility. Insurance plans, whether based on the fee-or-service or prepayment method, will set or negotiate a cost for reimbursement of skilled services with the facility providing the services. Medicare and Medicaid have set prices of reimbursement for each skilled service procedure. The price negotiated or set by managed care organizations, Medicaid, or Medicare is often a discounted price. This prevents the long-term care facility from receiving full reimbursement for services provided, potentially reducing the profit margin for the facilities.

Other implications could be the billing process. Long-term care facilities are often small enough that fewer people handle the billing process which would make one think fewer errors, but that is not the case. One person can handle patient access, certifications and authorizations, and the creating and submitting the billing claims. If the nursing and therapy staff are not capturing all the services provided, the coder can not provide billing codes for all the provided

services. This causes the biller not to submit all charges on the claim, again reducing the profit margin. While some long-term care facilities have access to corporate input and review of claims, if the services are never recorded the "second set of eyes" cannot catch it either.

Payer mix can hurt the profit margin in long-term care facilities. Payer mix is the percentage of payer sources within a facility. Often, long-term care facility administrators want to know the percentage of how many residents with Medicare and Insurance payers. Medicare and insurance payers are where the facility administrators are hoping to bring in the most profit. Private pay and Medicaid-pending residents pose a risk of creating a monthly debt that will potentially not be collected. Since Medicaid pays a set amount of the charges, the facilities know they will only collect a portion of the charges for the services that will create a minimal profit, break-even on charges, or loss of profit. If the payer mix of Medicare and insurance payers is too low, the facility will not be able to offset the decreased reimbursement from Medicaid and potential debt not able to be collected.

Perception Ranges for Quality Care and Quality of Life Expectations

Quality care, including the quality of life, is a range of perceptions. Whether asking a resident or the federal agency, the opinion of quality care will differ. Patients will lean toward experience, while their family members will have a range of expectations that cover their perception of quality care. Federal and state agencies have applied many regulations to ensure their standards of quality care to be implemented. Unfortunately, according to Robichaud, Durand, Bedard, & Ouellet (2006), very few studies actually consider the opinions of residents and families. A reason for this lack of research is due to long-term facilities allowing access to the residents within their facilities (Schenk, Meyer, Beher, Kuhlmey, & Holzhausen, 2013). The

following will explore the range of perceptions surrounding quality care, including those of residents and families.

Patient Expectations.

In one study, nineteen residents and eight family caregivers were interviewed (Robichaud et al., 2006). Eleven of the residents interviewed had a stay longer than 6 months, and five had a stay of less than six months (Robichaud et al., 2006). Residents and family members spoke about a range of ideas for environment, quality care, to financial well-being of the facility in the study conducted by Robichaud et al. (2016).

During the study, residents were concerned about their fellow residents (Robicahud et al., 2006). According to Robichaud et al. (2006), "According to the residents, the human environment should give them an opportunity to share enjoyable moments, take care of others, feel like part of a group, feel respect within a relationship, admire others, and even gossip." Another set of interviews completed by Schenk et al. (2013) confirms that residents expect someone to talk to, helping other residents, and enjoying time together with someone they can trust. These results show residents want and need a long term care facility to feel like home. The activities listed from the resident were normal activities they would have participated in if they were living in the surrounding, outside community. By being able to participate in the community, it increases the quality of life for themselves and the other residents around them (Robichaud et al., 2006).

While residents are concerned about their fellow residents, they do have an opinion of the type of care they prefer from the caregivers. Once example from a transcript during the study made by Robichaud et al. (2006), "it is clear that some residents would like to see a nurturing

role enacted toward and round them." Residents want to feel like family, like the caregivers really care about their health. During the study by Robichaud et al. (2006), Resident 10 with moderate dementia said "Giving care to someone, it's a kind of love, and we received as much as we give. I know that, because that's what I did all my life" (Robichaud et al, 2006). According to Schenk et al. (2013), residents want to be treated as competent adults.

Residents notice when the facility faces financial struggles. Residents are concerned about resources the long-term care facility can provide (Robichaud et al., 2006). Resources can impact the resident's activities and experiences (Schenk et al., 2013). Resident 13, of the study conducted by Robichaud et al (2006), stated:

> In the last few years, the needs have increased and the financial resources have decreased. The nursing home is no longer adapted to the elderly who were either very ill or impaired. It is difficult for the staff and for us too, you know.

Residents do not need to worry about financial hardships hindering their experience within a nursing home or other long-term care facility. Residents need reassurance resources are still available to them, and the facility is still committed to their health, physical and emotional. Residents need to feel like they are a part of something; they need to feel like they are still alive and a part of the changing community around them (Robichaud et al., 2006). Schenk et al. (2013) states, "Meaning can be generated by activities that make residents feel useful and engaged and/or that give them pleasure, enjoyment, or other positive feelings."

This may seem like more of a quality of life research, but improving one's quality of life improved the care of the resident's mental health. "Quality of life can be defined by the feeling

of well-being, satisfaction of needs, a favourable objective evaluation on the life conditions from another person, and no mental disease symptoms" (Robichaud et al., 2006).

Overall, residents are expecting facilities to provide time for them to care and interact with their peers (Robichaud et al., 2006). Residents would like their family members to care for them physically and emotionally (Robichaud et al, 2006). Care managers need to provide loving care while creating a relationship of devotion, respect, and compassion (Robichaud et al, 2006). Presence of transparency, confidence toward the residents, and effective security from the health professionals is how the residents would like the environment and care to be given (Robichaud et al., 2006).

Family Member Expectations.

Family member expectations for quality of care often differ from resident expectations. As shown from studies in the past, previously reviewed, residents focus on each other more towards their quality of life. Family members focus more on the quality of services and facility resources and conditions. Using information from the same study presented that was conducted by Robichaude et al. (2006), eight family members were interviewed to provide their opinions for understanding throughout this section.

When family members were asked about qualities of a caregiver, the family members gave a variety of answers. "Families stressed the availability of the caregivers, good will, helpfulness, loving care, sympathetic involvement, reciprocity in relationships, competence, and respect," according to Robichaud et al (2006). Again, according to Kiljunen, Kankkunen, Partanen, and Valimaki (2017), family members expected their residents to be interacted with and treated respectfully. Family members are wanting their residents to be treated by nurses that

have competencies to provide the highest quality of care, while creating the possible grade of quality of life.

Availability of caregivers is an important factor to family members. One family member felt the caregivers should be attentive to the resident needs by listening, giving undivided attention, and leave their personal problems at home (Robichaud et al., 2006). This idea from family members gives the conclusion that family members want residents to be the utmost priority to the caregivers.

Interpersonal communications were important to the quality of care and life given to the residents. Feeling of respect, creation of relationships, and actions and/or attitudes of the staff, directed more towards the direct caregivers, were detailed characteristics of communication expected from the caregivers (Robichaud et al., 2006). A similar response was given from residents as previously explained in this paper. Family members want the caregivers to be able to read the non-verbal communication from the residents and be able to provide the appropriate treatment of an elderly person (Kiljunen et al., 2017). Communication from caregivers is expected to keep the family members informed of the condition of the resident, while supporting the family members involvement in the decision making process (Kiljunen et al, 2017). Family members, just like residents, want their residents to be treated with dignity and respect, to make them continue to feel like a human being instead of a job.

Competence is a valuable quality to have from a caregiver because it influences the opinions for satisfaction of family members and residents (Kiljenen et al., 2013). According to Kilijenen et al. (2017), family members expect residents to receive the highest quality of basic care needs and support individually and holistically (p. 1018). Basic care needs to be delivered

with the resident's preferences considered and respected. While caring for the resident, caregivers should be aware they are also caring for the family members emotional well-being. Kilijenen et al. (2017) found that when caregivers support the family member's emotional well-being, family members take notice and value the efforts.

While caregivers are a major concern, the physical and facility environment. Topics included organization structure, material and human resources, programs and activities, physical layout and external links according to Robichaud et al. (2006). During the study conducted by Robichaud et al. (2006), a family member stated, "It is important for my mother to know that she has access to a lot of activities, including chapel. Usually, she goes every Sunday morning, it's important for her." According to Kiljunen et al. (2017), facilities need to provide recreation and activities is an important resource in the promotion of a resident's well-being. Also, family members are looking for the facility to encourage the social interactions and participation in the resources of recreation activities provided by the facility (Kiljunen et al., 2017).

Family members are concerned about residents and their relationships with other residents, however, the family members are more concerned about the environment (Robichaud et al., 2006). Robichaud et al. (2006) study found that open spaces, private rooms, and programs were important to the family members for their resident loved ones. A family member stated, "If there is not enough space in her room, she can not move easily with her wheelchair. The private room is very important, she spends her entire day in the room" (Robichaud et al., 2006). We can go back to the resident section and see a difference of opinion, not all residents want a private room.

Family members base their opinions from their observations during their stay and what they, the family member, thinks the resident's wants or needs. The wants and needs of families are spanned over a variety of expectations. Overall, the family members want the residents not to feel any financial restrictions, only the availability of caregivers and health professionals (Robichaud et al., 2006). Along with residents having access to resources, such as activities and spiritual services (Robicahud et al., 2006). Family members want residents to have access to a clean, friendly facility with private rooms and extra space (Robichaud et al, 2006). Resident's family members want their criticism, advice, and views to be taken into consideration to improve the quality of care and life for their loved one and the residents around them.

Facility Expectations.

Long-term care facilities fall under federal and individual state regulations that must be upheld to provide the best quality of care and quality of life. While these regulations are a base line of expectations from the government, facilities want to be the best in their industry of long-term care. We can conclude the facilities recognize they need to go above and beyond the base lines set forth on quality care and quality of life to be the best facility for the residents and their family members. Facilities evaluate the care and respect given to their residents and families. Activities and resources provided by the facilities will constantly be evaluated. Facilities will focus on caregiver competencies to provide care and respect needed for the residents and the family members. Environment and space will continue to be reviewed by the facility for the best interests of the residents.

Facilities provide caregivers that are certified, licensed, and/or experienced professionals to provide exceptional care. According to "The Metropolis Difference" (2020), they address the

needs of residents by collaborating with the resident, family member, physician, and recovery team to make the optimal care plan for the resident. This facility focuses on the individualized plans to create an improved quality of care system.

Facility caregivers are expected to have experience with a wide variety of diagnosis and treatments (Parkview Rehabilitation Center, 2020). Parkview Rehabilitation Center (2020) states, "We recognize that positive patient and facility outcomes only happen with dedicated, engaged associates who are driven by excellence." This statement gives evidence that facilities are expecting caregivers to be able to above the baseline standard for quality care and quality of life. Opportunities are given for education and advancement training from facilities to enhance the commitment for facilities and staff to provide quality patient care (Parkview Rehabilitation Center, 2020). Facilities want their caregivers to give the most up-to-date, patient care available.

Environmental spaces in facilities are based on the idea of a home-like environment and individuality. According to Misty Meadows (2018), they value independence and privacy. Again, "Rehabilitation and Skilled Nursing Rooms" (2020) offers secure and comfortable rooms to relax and recover. Facilities focus on replicating a home-like environment with security, furnishings, setup, and independence.

Long-term care facilities conduct surveys to cognitive residents and their family members to improve the quality of care and life given. The facilities distribute their surveys through different methods, such as: telephone, mailings, and e-mails. According to "About Our Survey" (2020),

> The survey is mailed and e-mailed to all current Metropolis Rehabilitation & Health Care Center residents and their family members. Recipients are asked to complete the survey

> and provide comments regarding specific aspects of care and services. We use this feedback to improve and enhance the care we offer. Surveys are mailed back to NRC for tabulation. Our communities receive their results with no identifying resident or family information.

These surveys give families a safe opportunity to voice their concerns and ideas about the facility's caregivers, services, environment, quality, and resources. Without family members' voices, facilities may not know it has an issue or where improvements are needed. The statement concludes that facilities want family members and residents to be involved in the community within the walls of the facility.

State Efforts to Obtain Quality and Staffing Requirements.

Federal laws set a standard, while states are allowed to make the law more strict as deemed necessary for their individual state. Each state has their own regulations for ensuring quality care and quality of life is given to each resident. For the purpose of this paper, the state of Illinois will be reviewed. Illinois has approximately 1,200 long-term care facilities containing approximately 100,000 residents from young to elderly patients (Nursing Homes). Illinois requires facilities to be licensed, regulated, and inspected by the Illinois Department of Public Health (IDPH), while assisting the U.S. Centers for Medicare and Medicaid Services (CMS) to certify facilities for participation in the federal reimbursement program (Nursing Homes). Also, not only among IDPH and CMS, long-term care facilities fall into an overlapping jurisdiction of the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) (Nursing Homes).

IDPH's mission is to "protect the health of the people in Illinois through the prevention, health promotion, regulation, and the control of disease and injury" (Ngoki Ezike, 2020, p. 8). IDPH has over 200 programs in place that affect the lives of residents and visitors to the facilities (Ezike, 2020, p. 8).

IDPH employees surveyors to conduct annual facility surveys, complaint surveys, and inspections (Nursing Homes). Each year the surveyors complete approximately 10,000 per year, including annual licensure inspections (Nursing Homes). Surveyors are provided with multiple sources of information at the time of hire and are continually trained to ensure the most current compliance information (Ezike, 2020). According to Ezike (2020), Basic Surveyor Orientation sessions cover information on:

> Complaint Training, Facility Tasks, PRessure ulcers, Supervision, Restraints, Immediate Jeopardy, Principles of Documentation, INvestigation Procedures, Deficiency Determination, Resident Rights, Infection Control, Pharmacy Tags, and Medication Pass, Environmental and Nutritional Requirements, Enforcement MDS/RAI, Kitchen, Environment, Involuntary Discharges, ROle of the Surveyor, and Automated Survey Processing Environment (ASPEN) products: Federal survey database" (p. 17-18).

Once training has been completed, at state and federal levels, surveyors are required to complete a Surveyor Minimum Qualifications Test (SMQT) (Ezike, 2020, p. 18). Surveyors continue to receive training after completion of the SMQT to ensure the surveyors have the most current compliance requirements at the state and federal levels (Ezike, 2020, 9.18). This information can give the conclusion that the state of Illinois puts surveyors through a vigorous training program to perform surveys of the facilities to ensure quality of care and life are given to residents.

The Division of Quality Assurance processes licensure and certifications surveys for long-term care facilities (Ezike, 2020, p. 26). According to Ezike (2020), "Surveys are conducted by the Division of Field Operations survey staff as mandated by the Nursing Home Act and the State Operational Manual in accordance with federally mandated timeframes" (p. 26). As researched above, the surveyors go through rigorous training to ensure their knowledge of the compliance and regulation requirements. Surveyors conduct these surveys on a complaint and annual basis. During the survey, surveyors review documentation, interview and observe staff, and review facility policy and procedures for compliance set forth by the state and federal regulations.

Long-term care facilities are heavily regulated by multiple agencies to help maintain a minimum quality of care or improve the standard. According to Ezike (2020),

> More than 1,000 facilities are regulated under the Illinois Nursing Home Care Act (NHCA), the ID/DD Community Care Act, the Medically Complex/Developmentally Disable (MC/DD) Act, the Specialized Mental Health Rehabilitation Act, the Community Living Facilities Licensing Act, and/or federal requirements for Medicare (Title XVIII) and/or Medicaid (Title XIX) participation. (p. 28)

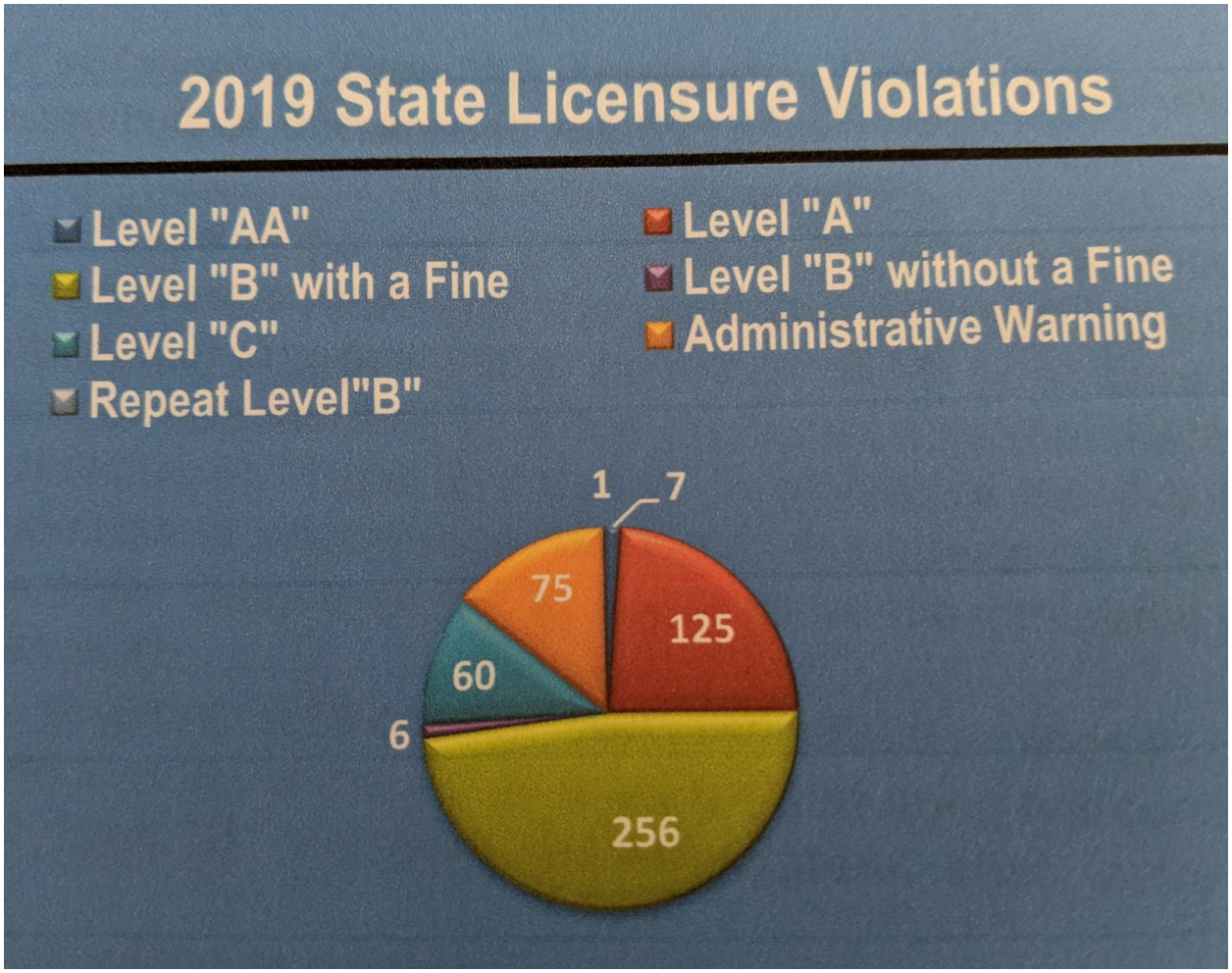
The number of licensed long-term care facilities under the NHCA or a nursing home under the Hospital Licensing Act is 834 (Ezike, 2020, p. 28). The majority of the 834 facilities, 94.13 percent, are certified by Medicare and/or Medicaid (Ezike, 2020, p. 28).

State violations are issued when the long-term care facility is non-compliant with regulations set forth by the agencies (Ezike, 2020, p. 29). Violations are rated at different levels of severity. The levels of severity are (listed in the from the most severe to the least): Level or

Type AA, level or type A violation, level or type B violation, level or type C violation, and administrative warning. Level AA is from Section 1-128.5 of the NHCA which is the most severe violation in action to "creating a condition or occurrence relating to the operation and maintenance of a facility that causes a resident's death" (Ezike, 2020, p. 29). From Section 1-129 of the NHCA, level A violations deal with conditions and maintenance of a facility creates occurrences that substantially may or does create risk of death or serious mental or physical harm (Ezike, 2020, p. 29). Conditions or occurrences in violation that are not likely to cause harm would be categorized under a level C violation under Section 1-132 of the NHCA (Ezike, 2020, p. 29). When finding violations that do not directly relate to the health of a resident, administrative warnings can be issued under Section 200.277 of the NHCA (Ezike, 2020, p. 29).

In 2019, 529 State licensure violations were issued (Ezike, 2020, p. 30). Of those 529, 395 violations were finable. Figure 3 illustrates the levels of these violations and fines.

Figure 3 (Ezike, 2020, p. 30)



While the state of Illinois can charge agencies and surveyors to hold facilities accountable for facility and operational regulations, health care workers fall under regulations.

Health care worker regulations help to prevent abuse from known abusers in the healthcare workforce. To keep abusers out of the long-term care facilities, IDPH has composed a variety of tasks for long-term care facilities to perform before the hire of staff to ensure they are hiring qualified staff.

One of the tasks required to perform a search for the prospective employee on the Health Care Worker Registry (HCWR) (Ezike, 2020, p. 56). The HCWR provides facilities with

information on unlicensed healthcare workers who will be in contact with residents, have access to resident's living area, and/or financial, medical, or personal records (Ezike, 2020, p. 56). The registry information includes "Certified Nursing Assistants (CNA) certifications, any finding of abuse, neglect, and theft, criminal background checks, disqualifying convictions, waivers which allow an exception to the prohibition of employment when there is a disqualifying conviction, and Developmentally Disabled Aide training" (Ezike, 2020, p. 56). An approved IDPH Livescan vendor performs a fingerprint background check to access certifications and potential criminal convictions (Ezike, 2020, p. 56). Once candidates are registered in the HCWR, the Illinois State Police send any new convictions to the Registry (Ezike, 2020, p. 56). Not only do the facilities have access to the Registry, the public can access the HCWR (Ezike, 2020, p. 56).

Any allegation of abuse, neglect or misappropriation of funds or property from any employee of the long-term care facility must be reported to IDPH according to the NHCA and Abused and Neglected Long-term Care Facility Residents Reporting Act (Eziked, 2020, p. 56). After investigation, the staff member is found to have committed abuse, neglect, or misappropriation of property or funds this information is published on the HCWR (Elize, 2020, p. 56). By making this information public, IDPH helps facilities hire a qualified staff without a record of abuse or neglect. IDPH cannot hire the staff for the facilities, IDPH can make sure facilities are receiving a quality staff.

Licensed staff must complete a program approved by the state of Illinois. The state of Illinois licenses nurses on three levels: Licensed Practical Nurses (LPN), Registered Nurses (RN), and Advanced Nurse Practitioners (ANP) (Nursing License Requirements in Illinois). Regardless the level of nursing, examinations and endorsement are required (Nursing License

Requirements in Illinois). In advance, applicants will have a fingerprint background check before the examination for licensure (Nursing License Requirements in Illinois). A conclusion can be made that the state of Illinois will allow nurses to sit for the examination only from an approved, quality program to ensure the new nurses are qualified to give quality care and provide quality of life for patients, including residents of a long-term care facility. In addition, the state of Illinois requires the candidate to be free of abuse in their background in regards to the criminal records.

Federal Expectations.

Long-term care facilities are required to be in compliance with Medicare and Medicaid policies issued by the CMS for federal level regulations, including their state level regulations. CMS restructured and reorganized the quality of care provisions in 2016 (A Closer look at the Revised Nursing Facility Regulations: Quality of Care, 2017). Surveyors continue to monitor facility compliance with extensive training of the regulations. The goals for regulations are "supporting person-centered care and enabling each resident to attain or maintain his or her highest level of well-being" (A Closer look at the Revised Nursing Facility Regulations: Quality of Care, 2017).

The changes were to make sure every resident's individual needs are met, not that facilities care and services are best for the majority of residents (A Closer look at the Revised Nursing Facility Regulations: Quality of Care, 2017). Resident's must continue to maintain or improve in condition, unless decline in condition is unavoidable (A Closer look at the Revised Nursing Facility Regulations: Quality of Care, 2017). According to "A Close look at the Revised Nursing Facility Regulations: Quality of Care (2017):

> In practice, a facility is out of compliance with quality of care requirements if it fails to implement the resident's care plan, which CMS views as the facility's determination of what care and services are needed, and must be provided, to enable the resident to achieve his or her highest practicable level of functioning. (p. 1)

This statement provides us with the conclusion that basic care alone is not enough, but individualized care identified within a plan will give the best quality of care for the residents.

Long-term care facilities that become deficient in the quality of care for their residents will receive federal certification deficiencies. According to Ezike (2019), the deficiencies are given "based on the severity of the problem and the scope, or the number of residents upon whom the non-compliance had or may have an impact" (p. 33). There are four levels for the severity for federal deficiencies: minimal harm, more than minimal harm, actual harm, and immediate jeopardy (Ezike, 2019). The severity is rated in scopes: isolated, pattern, and widespread (Ezike, 2019). The scope of severity is given an identification of letters A through L, according to Ezike (2019, p. 33). Figure 4 explains the severity in relation to the scope and level. Immediate Jeopardy (IJ) are the most serious deficiencies that show non-compliance has occurred and either has or is likely to cause a resident some form of harm or death (Ezike, 2019, p. 33). Deficiencies are given to help encourage facilities to maintain quality care for residents, and give a discipline for not following regulations that would enhance and provide the residents with the quality care deserved.

Figure 4 (Ezike, 2016, p. 33)

SEVERITY	ISOLATED	PATTERN	WIDESPREAD
Minimal Harm	A	B	C
More Than Minimal Harm	D	E	F

Actual Harm	G	H	I
Immediate Jeopardy	J	K	L

When deficiencies are given, long-term care facilities must provide a remedy to correct the deficiency to prevent termination of provider agreements and enforcement actions (Ezike, 2019, p. 33). The severity of the deficiency determines the types of corrections that need to be implemented to correct the issue. The correction remedies can include: directed plan of corrections (DPOC), directed in-service training (DIST), denial of payment for new admissions (DPNA), discretionary denial of payment for new admissions (DDPNA), state monitor (SM), civil money penalties (CMP), temporary management (TM), and termination from Medicare and Medicaid participation (Ezike, 2019, pp. 33-34).

Summary of Quality.

Each person, facility, and government entity wants the best quality of care and life that can be given by any facility and their staff, licensed or unlicensed. Each may not agree what is the definition of quality care and/or life, they all have the same goal to make the resident happy, comfortable, safe, healthy, and to maintain or increase well-being. Residents voice their concerns to staff, family members, and surveyors. Family members voice their concerns to staff, other family members, and surveyors. Facilities communicate with residents and family members to provide the best information about their resident, the needs of the resident, and any hindering legal obligations that may pose as an opportunity or issue, i.e. HIPAA. Surveyors have a tough obligation to interpret the regulations and ensure the facility is following them. Also, surveyors have to determine the severity of any deficiencies that arise, which is another

tough task for the surveyors. Depending on the type of survey, the surveyor will communicate back with the family member or resident that had an issue about any findings.

Staffing Requirements

Residents, family, facilities, state level agencies and federal level health agencies set their goals to provide quality of care. Staffing levels plays a major role in the ability to provide quality care for individuals and their individual care plans. Depending on the source, each source will have a different view and/or requirement to fulfill quality care.

Family Thoughts on staffing.

When problems arise, one of the first reasons that is believed to be the origin is the necessity for more staffing on a shift. Residents and family members view the appearance of staffing daily and will come to the conclusion that more staffing would solve their part or all of the issue that has arised. Resident and family thoughts are not always a researched decision, but a decision that is assessed based on how the resident and family feels the situation should be handled. In the state of Illinois, long-term care facilities are required to post their staffing sheets daily for anyone, including visitors, to review. The daily staffing sheets will give the residents and families an idea of the staffing levels for the day, but a full scope of staffing throughout the whole facility.

Facility and Staff perspective on staffing.

According to Harrington, Schnelle, Mcgregor, and Simmons (2016), “nurse staffing levels are too low in half of U.S. nursing homes.” Long-term care facilities are following the guidelines for staffing set forth from the state of Licensure and CMS. Some states have higher staffing requirements than those issued by the federal standards, however, levels are still below

recommended expert advice (Harrington et al., 2016). There is a limitation of finding staffing requirements for facilities; the facilities acknowledge they meet the guidelines set forth by the state regulation and CMS.

Staff in the facility believe they are overworked and sometimes are asked to go farther than their scope of practice. According to Dyck, Novonty, and Aaron (2016), "research in nursing homes suggest that RNs are not practicing to the full scope of their practice and LPNs are practicing beyond the scope of their practice." While RNs are not utilized to their maximum scope of practice, requiring LPNs to work beyond their scope of practice is a regulation issue. Dyck et al. (2016) found that 60% of RNs and LPNs do the same treatments and services. Dyck et al. (2016) stated,

> 73.4% of LPNs analyze assessment data to form a nursing diagnosis with 93.3% of LPNs completed an admission assessment. 60% of LPNs develop a comprehensive care plan, 83.9% delegate interventions for care plan implementation and 63.9% evaluate resident outcomes.

A conclusion can be made that LPNs are practicing outside their scope of practice and either more staffing of RNs needs to occur or restructuring of the facility staffing assignments need to be evaluated.

Illinois Staffing Requirements.

In efforts to follow the recommendations set for by the federal government, Illinois has a minimum staffing requirement for long-term care facilities. Only the number of direct staff are able to be counted towards the staffing requirements. These requirements include certified nursing assistants (CNA), LPNs, and RNs, unless a resident has a diagnosed mental illness

requiring therapists and therapy aides (Minimum Required Staffing). The staffing requirements are based on the number of residents needing each of skilled or intermediate care by the specific number of hours required for that type of care.

According to Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (c),

> the number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day.

Skilled nursing residents are required to receive 3.8 hours of total nursing time daily (Minimum Required Staffing). According to "Minimum Staffing Requirements," 57 minutes of licensed nursing time is required for each resident with 23 of those minutes performed by a RN. Intermediate residents are required to receive 2.5 hours of total nursing time daily (Minimum Required Staffing). According to "Minimum Staffing Requirements," 38 minutes of total nursing time is to be given to residents including 15 minutes of RN time. Examples of computation of the requirements are illustrated below in figures 5 and 6:

Figure 5 (Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (2)(A))

Total Minimum Hours of Care Needed

Level of Care	# of residents	times	Total Hrs. Needed/Day Per Resident	Total Hrs. Needed/Day Per Facility
Skilled	25	x	3.8	9.5
Intermediate	75	x	2.5	187.5
			Total Hours Needed	282.5

Figure 6 (Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (2)(B))

Minimum Total Hours Needed Per Shift

Shift	Total Hrs. Per Day	Times	Minimum Percent	Total Hours Needed
7-3	282.5	x	45%	127.125
3-11	282.5	x	35%	98.875
11-7	282.5	x	20%	56.500
			100%	282.500

The Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (2) provides further chart examples for required licensed nurses expanding on the registered nurses and direct care staff for reference for facilities to abide by.

While there are minimum staffing requirements set forth by the state of Illinois, facilities are still expected to schedule staffing to meet the needs of the residents. Administrative Code, 77, Joint Committee on Administrative Rules 300.1230 § (d)(1)(2), "Each facility shall provide minimum direct care staff by (1) determining the amount of direct care staffing needed to meet the needs of its residents; and (2) meeting the minimum direct care staffing ratios set forth in the Section."

Illinois requires long-term care facilities to post for the public the nursing staff on each shift including their name and title (Minimum Required Staffing). All employees are required to wear name badges with their licensure and job title or position (Minimum Required Staffing).

Federal Staffing requirements.

Staffing levels should meet and/or exceed the appropriate staffing to provide quality care and needs of the residents in long-term care facilities. There is not an enforcement of a minimum level of staffing for long-term care facilities from the federal government (Minimum Required Staffing). According to "Minimum Required Staffing,"

> It does recommend that each resident who needs skilled care get at least 4.1 hours of nursing care every day, including 1.2 hours (72 minutes) by a licensed nurse. The federal government recommends that 45 minutes of the 1.2 hours be cared for by a registered nurse.

For example, Illinois has set minimum staffing requirements in efforts to meet and/or exceed the recommendations set for at the federal level. As mentioned many times in the Administrative Code, 77, Joint Committee on Administrative rules 300.1230, facilities should be staffing according to the needs of the residents along with the minimum number set forth.

Staffing Reimbursement Methods

The standard method of compensation for long-term care facilities include a rate per hour, shift incentives, experience incentives, sign-on bonuses, health insurance, secondary insurance, bonus programs, time-off packages, monthly recognitions, continuing education incentives, and team building activities. Facilities have different ideas for staff reimbursement and growth within the individualized facility. Not every facility offers all of these compensation methods, facilities utilize what works best for it. Also, it must be noted that facilities utilize these methods and more depending on their needs and resources. For the purpose of this paper, we will focus on the most common reimbursement methods between facilities.

Rate per hour.

The state of Illinois has set a minimum wage of $10.00 as of July 1, 2020 (Minimum Wage Law, 2020). According to Minimum Wage Law (2020), anytime over forty hours must be compensated to the employee at the rate of time and one-half per hour. An annual salary of a position compensated at minimum wage earns an annual salary of $20,800. The national average annual salary for a CNA is $27,840 in the long-term care environment; this can be broken down to $13.38 per hour (RegisteredNurse.org, 2020). For CNAs working in Illinois, Illinois lands just above the national average at $27,860 annually or $13.39 per hour (RegisteredNurse.org, 2020). The LPN national annual average salary is $43,528 or $20.92 per hour (Long Term Care Nursing Careers & Outlook, 2020). The average annual salary for a RN in long-term care is $50,000 or $24.03 per hour (Long Term Care Nursing Careers & Outlook, 2020). Often regardless of nursing position, staff are offered a shift differential anywhere from $.10 an hour to $3.00 an hour on top of their base rate per hour. Some facilities take into consideration years of experience in their certified or licensed field of expertise to give a rate per hour incentive.

Incentives and benefits.

In efforts to attract and retain quality CNAs or RNs, facilities will offer sign-on bonuses. A sign-on bonus can be in the range of $250 up to $10,000 or more depending on the position and the facility needs. Smaller sums are paid over a few months, while larger sign-on bonuses are paid out over a period of time, i.e. years, in efforts to retain the staff member longer.

Staff can be offered multiple types of insurance. Health insurance options meet the requirements set forth by the Affordable Care Act (ACA). Employers usually cover up to 70% of the health insurance cost leaving the employee paying only 30% (Miller, 2020). Secondary

insurance offered to staff include critical illness, accident, cancer, wellness, and short-term disability.

Time-off Incentives.

Long-term care facilities will entice staff with time-off benefits. Staff are able to accrue vacation, sick, personal, and/or paid time off hours to use within the policy requirements. Some facilities offer only one type of time-off benefits, while other facilities will offer a combination on the above listed. Time-off benefits give staff the ability to manage their work-life balance.

Pay for Performance Pay Incentives Effectiveness in Long-term Care Facilities

From this point forward of this research paper, we will focus on the nursing home industry of long-term care facilities. Staff turnover is a major problem in nursing home facilities due to poor wages or reimbursement methods and working conditions (Weissert & Frederick, 2013). Unfortunately, the turnover rate affects the resident due to the lack of stability and continuous care from the lack of having resident familiarity (Weissert & Frederick, 2013). Also, nursing homes maintain quality by adhering to regulations, therefore, staff turnover can hurt the compliance levels within the facility.

According to Weissert and Frederick (2013), nursing homes fall short of regulatory minimums for targeted levels of quality. As described previously, surveyors assess the facility on an annual or complaint basis for compliance standards at the federal and state levels, along with certifications with CMS (Weissert & Frederick, 2013). Compliance fines can be costly and as reviewed previously, Medicaid reimburses as little as possible creating a setting to punish bad care and not reward quality care (Weissert & Frederick, 2013).

Pay for performance pay incentives.

Pay for performance reimbursement, value-based purchasing, has been implemented by CMS to improve care based on quality measures established and the reimbursement amounts will be based on the quality of performance (Weissert & Frederick, 2013). According to Weissert and Frederick (2013),

> It typically involves setting aside funds above the base salary as a bonus to be awarded to a facility and its employees if they achieve specific performance goals or outperform others. In health care settings, those goals most often involve achieving improved patient health status or at least providing care that is expected to produce improved health status (p. S140).

It can be concluded based on the statement from the previous statement from Weissert and Frederick (2013) that nursing home facilities are receiving extra funds for a quality performance. If the facility is receiving extra funds for a quality performance, why are staff not being rewarded with extra funds or reimbursement programs for each individual's performance?

"When employees receive incentives, input, and feedback for specific, challenging goals, they perform better," according to Weissert and Frederick (2013). Pay for performance pay incentives would encourage input and feedback because their reimbursement would reflect their performance and goal to provide a better quality care. Nursing homes would be a suitable industry for the pay for performance pay incentives because of the many routine tasks performed (Weissert & Frederick, 2013). In the perfect world, pay for performance pay incentives in a nursing home would improve the quality care, the amount of care, and to give low performing staff an incentive to improve their individual performance (Weissert & Frederick, 2013). According to Weissert and Frederick (2013), some factors that make nursing homes well suited

for the pay for performance pay incentives include 1.) tasks are routine and for the most part nontechnical, 2.) the nursing home industry is mostly made up of for-profit organizations, 3.) chronic conditions and the range of problems outcomes improvements, 4.) workers are lower wage employees when compared against the entire healthcare industry, and 5.) There is room for improvement in the nursing home industry.

Pay for performance pay incentives applied in thirty-six nursing homes.

Weissert and Frederick (2013) reviewed a study of the pay for performance pay incentives applied in nursing homes. "The theory behind the study was that the way in which nursing homes are paid affects their effort, which, in turn, affects the health of residents," state Weissert and Frederick (2013, p. S148). Assuming most nursing homes are for-profit facilities, the study assumed the facility goal was to obtain maximum profits (Weissert & Frederick, 2013). The study included thirty-six for-profit Medi-Cal (California's Medicaid program) skilled nursing facilities over the span of two-and-half years (Weissert & Frederick, 2013). Each facility had a minimum of 30 beds creating an assessment of 2,400 patients for the study (Weissert & Frederick, 2013). According to Weisserty and Frederick (2013), a six month baseline and one year of admissions were used.

Three bonuses were offered during the study: 1.) admission of severely dependent, heavy-care patients whose care will be expensive, 2.) discharge of medically-ready patients without readmission within ninety days, and 3.) achieving specific goals in patients that require expensive care to maintain or improve their health status (Weissert & Frederick, 2013). Since the assumption was made maximum profits was the goal, bonuses were formulated for the facility to still achieve maximum revenue (Weissert & Frederick, 2013). For maximum

revenue, the bonus payments were constructed around the facility bonus of: 1.) admission bonus for extra costs on the expensive patients, 2.) successful outcomes resulted in double their cost, however, unsuccessful outcomes resulted in zero income received, and 3.) discharges were successful without death or readmissions within ninety day to a hospital or nursing home (Weissert & Frederick, 2013).

In this study, researchers found the pay for performance pay incentives worked as expected (Weissert & Frederick, 2013). Weissert and Frederick (2013) found "each performance goal was reached" with evidence of increased admissions of complex case mix, improved patient health outcomes, and increased successful discharges. Weissert and Frederick (2013) stated,

> Under the incentive system, healthier patients were discharged, freeing room in the nursing homes for sicker patients. Therefore, those in the hospital waiting for a bed were able to be discharged sooner saving hospital costs….Medicaid would save about twenty percent per stay as a result of shorter hospital stays. (p. S148)

Based on the information provided, the facility reached goals to receive its bonus incentives as a result of having motivated staff to provide more and quality care for the residents.

Improvements observed in the study.

Weisserty and Frederick (2013) stated, "it is very encouraging that facilities that were the worst performers at baseline showed improvements of nearly ten percent, well above the median for most studies" (p. S146). Not only does improvements in quality care come from participation in a pay for performance pay incentives, but hospitals improved at a higher rate

(Weissert & Frederick, 2013). Hospitals, just like nursing homes, saw most improvement at the baseline level (Weissert & Frederick, 2013).

Examples of condition improvements were provided by Weissert and Frederick (2013) for asthma care quality and influenza vaccination improved with the system goals. Success with immunization rates and tobacco counseling increased when utilizing incentives, feedback, and goals (Weissert & Frederick, 2013).

Issues with implementation.

Pay for performance pay incentives and other merit based incentives have not been successful and have little impact on employee motivations and performance in the overall public sectors (Weissert & Frederick, 2013). While the study does provide information to believe the pay for performance pay incentives will work, implementation is key to success. Some programs will fall short of success due to poor design (Weissert & Frederick, 2013). Facilities need to assess if there is room for improvements and decide the measures needed to be in place (Weissert and Frederick, 2013). Weissert and Frederick (2013) stated that problems "range from trickle-down payment that does not reach actual caregivers, to cream skimming of new admissions, to payments too small to induce behavior change, and many others" (p. S141). Complexity of incentives and performance targets can hinder the implementation with inadequate training and monitoring (Weissert & Frederick, 2013).

Implementation issues to avoid are 1.) the slippery slope, 2.) the "distortion effect," 3.) cream skimming, 4.) design failures, and 5.) implementation failures (Weissert & Frederick, 2013). The slippery slope identifies demands for "risk compensation," paying for conditions that do meet the criteria, meaningless outcomes, outcomes with no change in performance, and better

documentation without improvements in outcomes (Weissert & Frederick, 2013). The "distortion effect" involves not providing care for patients that would not be a part of the bonus program (Weissert & Frederick, 2013). Facilities that start choosing which patients they admit in order to achieve bonuses is cream skimming (Weissert & Frederick, 2013). When facilities have bonuses connected to too many outcomes, the staff begins to feel overwhelmed creating design failures (Weissert & Frederick, 2013). Implementation failures include inadequate training and monitoring (Weissert & Frederick, 2013).

Recommendations

Long-term care facility administration teams need to start by reviewing the mission, vision, values, and culture within the facility before they can make an effective strategic plan to implement the pay for performance pay incentive. According to Harrison (2016),

> An organization's mission, vision and values provide the foundation on which its strategic plan is built. Consistency among mission, vision, and values and clear links amount all three enhance the strategic planning process and increase the chance of performance improvement. (p. 80)

If the entire workforce has not bought into the mission, vision, and values, implementation of the pay for performance pay incentive will be difficult (Harrison, 2016). The culture, shared values and beliefs among the employees, will be affected as well. The cultural beliefs will provide a framework for behaviors (Harrison, 2016). According to Harrison (2016), culture guides the facility's decision making for allocation of resources and establishment of priorities (p. 80).

"Goals should be clearly measurable and attainable and that ensure accountability are the primary prerequisite to achieving success," stated Harrionson (2016, p. 70). Goals need to meet

three basic conditions in regard to organizational values and standards: 1.) be consistent with the values of the organization, 2.) be specific, and 3.) specify actions that will be taken to comply with the values and standards of the facility (Harrison, 2016, p. 70). CMS has implemented pay for performance reimbursement for specific outcomes and goals. Facility administration should be able to create a strategic plan for implementation of pay for performance pay incentives that coincide with the facility values and standards, as well as the CMS outcomes and goals reimbursement. Goals and their strategic plan should be monitored regularly and changing with the needs of the facility to ensure the maximum result is being met.

While the pay for performance pay incentive program is focused on the staff performance in regards to quality care, the administration team will need to review the leadership style within their facility. The administration team will help create the culture for the success of the implementation of a strategic plan to incorporate the pay for performance pay in entives. Harrison (2016) stated, “transformational leadership is important to an executive’s success and is a critical resource in an organization's ongoing strategic planning process” (p. 68). The ideal form of leadership is transformational leadership versus the more authoritative, transactional leadership. Transformational leadership will inspire awareness to the team, maintain goals, empower the employees, make team decisions, focus on quality, align vision and goals, and increase productivity (Harrison, 2016). Staff morale, positive emotions and a sense of common purpose among the group, will increase, creating an increased productivity (Harrison, 2016).

Attributes contributing to the success of transformational leaders include the following: being visionary or futuristic, ability to catalyze followers, motiviatation, goal orientation, expertise, flexibility, excellent communication skills, and innovation of group respect, shared

vision, and improved culture (Harrions, 2016, p. 66). Personality characteristics that contribute to the successful transformational leaders include the following: self-knowledge, self-confidence, positive self-image, authenticity, charisma, intelligence, and ability to empathize with followers (Harrison, 2016, p. 66). According to Harrison (2016, p. 67), "the transformational leadership approach is considered highly effective in improving patient safety." Transformational leadership not only empowers employees, but encourages patient safety which will encourage quality care. Pay for performance can be affected if the wrong leadership style is trying to implement the strategic plan for the pay for performance pay incentives within the facility. Transformational leadership is a factor to consider when implementing the pay for performance pay incentive or any other strategic plan within the facility.

Transformation leaders in the administration will use the following strategies to be successful: 1.) uphold integrity, 2.) get down in the trenches, 3.) communicate, 4.) have meetings, and 5.) keep the mission in minds (Harrison, 2016). Transformational leaders will always be honest and true to the values of the facility (Harrison, 2016). Leaders that are willing to perform any task that the leader would ask for staff and be an example creates respect (Harrison, 2016). Making sure the lines of communication are always open from both sides, leadership and staff, continue to create commitment from the staff (Harrison, 2016). Meetings help the team discuss all ideas of implementation to keep employees involved with the plan (Harrison, 2016). As always, the mission should be important to all employees, plans, outcomes, and activities with the facility. Harrison (2016) stated,

> Transformation leaders focused on linking their followers with goals and values by developing a common cause. When they do so successfully, they bome motivators,

> facilitators, educators, and visionaries. Followers develop a high degree of confidence in their direction and sense of loyalty. (p. 65)

Five core areas the strategic plan for implementation should include: 1.) healthcare quality, 2.) patient access, 3.) employee retention, 4.) differentiation in the market, and 5.) alignment of resources (Harrison, 2016). Pay for performance pay incentive illustrates effectiveness in all the five core areas. Pay for performance pay incentive ultimate goal is to provide the very best, quality care to residents. In turn, residents receiving quality care should result in a successful discharge creating more rooms for patients to be admitted increasing the access of the facility. While the ultimate goal is quality care, pay for performance pay incentives will help employee retention. All facilities should be acquiring to be the best quality care in the industry, but adequate staff providing quality care will stand out in the market. Recruiting quality employees will increase because of the revised pay incentives due to the available funds the facility receives from the bonuses from providing successful outcomes and quality care. "Because of the changing healthcare environment, effective leaders who wish to maximize organizational performance focus their efforts on recruiting the best individuals available," stated Harrison (2016, p. 155).

Minimum wage increases across the state of Illinois will continue to the year of 2025 reaching the peak of $15.00 per hour. The increase of minimum wage will affect the CNA, LPN, and RN wage difference for each position's education, experience, work load, and knowledge. The pay for performance pay incentives will help increase the reimbursement rate for the staff efforts to provide quality care based on each individual's performance.

Special regard needs to be taken into consideration for those employees who are not monetary driven. Some staff are internally motivated, feelings like enjoyment from a job well done. These staff will continue to provide the best quality care they can provide as long as the leadership style is effective. The pay for performance pay incentive is a reward system based on external rewards, for example reward or money as the motivation. While money is a great motivator, the threat of punishment only works with some, therefore, you are not going to achieve the desired result.

Conclusion

Pay for performance pay incentives can be successful if goals, leadership, staff, and implementation are aligned. Residents, family members, facilities, surveyors, and CMS should see some improvements with the implementation of the pay for performance pay incentives. Everyone, from the resident to the leadership to CMS, should see an increase of improved quality of care.

Residents and family members expectations for quality care do vary some. Pay for performance pay incentives can help promote and achieve their expectations while still working towards the outcomes and goals set forth by the facility and CMS. Pay for performance pay incentives help encourage the staff to be more engaged with the residents, in turn helps the staff be just as engaged with the family members.

Long-term care facilities will always have goals and outcomes they are looking to move toward. Facilities can utilize the pay for performance pay incentive with success if implemented properly. The facility will have to properly monitor and review the process to determine the success of the program. However, facilities need to recognize the level of quality they are

starting at. If the facility is already at a high level of compliance and quality care, the facility will not see much improvement from the implementation of the pay for performance pay incentive. The pay for performance pay incentive would be just that, a pay incentive for staff which would be acceptable if staff are receiving inadequate wages. This would need to be reviewed during the strategic planning process for the effectiveness for that individual facility.

As assessed in this research paper, when problems arise the first thing families and residents blame is the staffing levels within the facility. Facilities believe the staffing levels are at minimum requirements of the state and CMS. Staff believe they are overworked and need more staff to properly care for residents. The pay for performance pay incentive should encourage staff to provide a little extra effort to perform the tasks of the position. The administration will need to monitor the success of the implementation of the pay for performance pay incentive. The review may determine staffing may need to be increased in smaller increments while still implementing the pay for performance pay incentive.

Surveyors should see an decrease in citations or tags for deficiencies in regards to regulations set forth by the state and CMS. "Even more encouraging is that lowest-performing facilities showed the highest rates of improvement in one hospital study," stated Weissert and Fredrick (2013,p. S149). Weisset and Frederick's statement does give encouragement to long-term care facilities, if the performing hospitals can increase performance and quality care then long-term care facilities can too. Pay for performance reimbursement from CMS should be used as one tool for monitoring the pay for performance pay incentive for staff. If CMS is reimbursing for larger rates, then the amount of reimbursement should reflect the amount of the quality care that is being given within the facility.

Weissert and Frederick (2013, p. S149) stated,

> For nursing homes, the nature of their patient care tasks, their limited range of targets for incentive payments, the low wage base of their staffs, and the record of greater likelihood of success in medical care settings than elsewhere may make them an ideal setting in which pay for performance can produce improved quality of care.

Pay for performance incentives can improve the quality care given by staff in long-term care facilities. Clear goals and outcomes with proper compensation will help ensure staff support. With the proper monitoring and implementation, facilities should have success with outcomes and goals using the pay for performance pay incentives.

References

A Closer Look at the Revised Nursing Facility Regulations: Quality of Care. (2017). *Justice in Aging*. Retrieved October 8, 2020, from https://theconsumervoice.org/uploads/files/issues/Revised_Nursing_Facility_Regulations_Quality_of_Care.pdf

About Our Survey. (2020, August 17). Retrieved September 25, 2020, from https://metropolisbytutera.com/about-our-survey/

Amenities. (2020). Retrieved September 03, 2020, from https://metropolisbytutera.com/amenities/

Annuities. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/costs-how-to-pay/paying-privately/annuities.html

Buchbinder, S. B., & Shanks, N. H. (2017). *Introduction to health care management*. Burlington, MA: Jones & Bartlett Learning.

Costs of Care. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/costs-how-to-pay/costs-of-care.html

Dyck, M., Novotny, N., & Aaron, C. (2016). Scope Of Practice Of Licensed Nurses In Illinois Nursing Homes. *The Gerontologist, 56*(Suppl_3), 239-239. doi:10.1093/geront/gnw162.955

Ezike, N., MD. (2020). *Long Term Care Annual Report to the Illinois General Assembly* (Rep.).

FAQS. (2020). Retrieved September 03, 2020, from https://metropolisbytutera.com/faqs/

Glossary. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/the-basics/glossary.html

Harrington, C., Dellefield, M. E., Halifax, E., Fleming, M. L., & Bakerjian, D. (2020). Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health Services Insights, 13*, 117863292093478. doi:10.1177/1178632920934785

Harrington, C., Schnelle, J. F., Mcgregor, M., & Simmons, S. F. (2016). Article Commentary: The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes. *Health Services Insights, 9*. doi:10.4137/hsi.s38994

Harrison, J. P. (2016). *Essentials of strategic planning in healthcare*. Health Administration Press.

Home, S. (2020). Short-Term Care. Retrieved September 03, 2020, from https://www.superiorcarehome.com/short-term-care

Kiljunen, O., Kankkunen, P., Partanen, P., & Välimäki, T. (2017). Family members' expectations regarding nurses' competence in care homes: A qualitative interview study. *Scandinavian Journal of Caring Sciences, 32*(3), 1018-1026. doi:10.1111/scs.12544

Long Term Care Nurse Careers & Salary Outlook. Nurse Journal. (2020, July 2). https://nursejournal.org/long-term-care-nursing/long-term-care-nurse-careers-salary-outlook/.

Miller, S. (2020, October 2). *Employers Project Health Plan Costs Will Rise 5.3% for 2021*. SHRM. https://www.shrm.org/ResourcesAndTools/hr-topics/benefits/Pages/employers-project-health-plan-cost-rise-for-2021.aspx.

Minimum Required Staffing. (n.d.). Retrieved October 09, 2020, from http://www.illinoiscares.org/content/minimum-required-staffing

Minimum Wage Law. (2020). Retrieved October 16, 2020, from https://www2.illinois.gov/idol/laws-rules/fls/pages/minimum-wage-law.aspx

Move-In & Admissions. (2020). Retrieved September 03, 2020, from https://metropolisbytutera.com/admissions/

Nursing Homes. (n.d.). Retrieved October 01, 2020, from https://www.dph.illinois.gov/topics-services/health-care-regulations/nursing homes

Nursing License Requirements in Illinois. (n.d.). Retrieved October 08, 2020, from https://www.nursinglicensure.org/state/nursing-license-illinois.html

Parkview Nursing and Rehabilitation Center. (2020). Care & Services. Retrieved September 03, 2020, from https://lcca.com/locations/ky/parkview-ky/services

Parkview Nursing and Rehabilitation Center. (2020). Careers. Retrieved September 25, 2020, from https://lcca.com/locations/ky/parkview-ky/careers

Patino, E. (2020, April 17). What You Need to Know About Speech Therapy. Retrieved September 03, 2020, from https://www.understood.org/en/learning-thinking-differences/treatments-approaches/therapies/what-you-need-to-know-about-speech-therapy

Paying Privately. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/costs-how-to-pay/paying-privately/index.html

Reed, K. L., & Sanderson, S. N. (2000). *Concepts of Occupational Therapy* (4th ed.). Philadelphia: Lippincott, Williams & Wilkins.

RegisteredNursing.org. (2020, August 27). *CNA Salary - What to Expect.* Registered Nursing.org. https://www.registerednursing.org/certified-nursing-assistant/salary/.

Rehabilitation & Skilled Nursing Rooms. (2020, August 17). Retrieved September 25, 2020, from https://metropolisbytutera.com/senior-studios-in-metropolis/

Reverse Mortgages. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/costs-how-to-pay/paying-privately/reverse-mortages/index.html

Robichaud, L., Durand, P. J., Bédard, R., & Ouellet, J. (2006). Quality of Life Indicators in Long Term Care: Opinions of Elderly Residents and Their Families. *Canadian Journal of Occupational Therapy, 73*(4), 245-251. doi:10.2182/cjot.06.003

Schenk, L., Meyer, R., Behr, A., Kuhlmey, A., & Holzhausen, M. (2013). Quality of life in nursing homes: Results of a qualitative resident survey. *Quality of Life Research, 22*(10), 2929-2938. doi:10.1007/s11136-013-0400-2

Services & Amenities. (2018). Retrieved September 03, 2020, from https://www.mistymeadowsseniorliving.com/amenities.html

Services. (2019, January 25). Retrieved September 03, 2020, from https://gaithersuites.com/services/

SNF PPS: Patient Driven Payment Model. (n.d.). Retrieved September 17, 2020, from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/MLN_CalL_PDPM_Presentation_508.pdf

State Medicaid Programs. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/medicare-medicaid-more/medicaid/index.html

The Metropolis Difference. (2020, August 17). Retrieved September 25, 2020, from https://metropolisbytutera.com/the-metropolis-difference/

Trusts. (2020, July 23). Retrieved September 10, 2020, from https://longtermcare.acl.gov/costs-how-to-pay/paying-privately/trusts.html

Weissert, W. G., & Frederick, L. F. (2013). Pay for Performance: Can It Help Improve Nursing Home Quality? Public Administration Review, 73(s1). https://doi.org/10.1111/puar.12074

Welcome home! (2018). Retrieved September 25, 2020, from https://www.mistymeadowsseniorliving.com/

What Is Physical Therapy? (2001, January). *Physical Therapy*, *81*(1), 21. https://link-gale-com.ezproxy.waterfield.murraystate.edu/apps/doc/A70453287/HWRC?u=murr79496&sid=HWRC&xid=a925823c

77 (2014).