



Coming Full Circle

OBRA Brought Substantial Change for the Caring of Nursing Home Residents. Yet, Much Work Remains Today for the Industry.

When the Omnibus Budget Reconciliation Act (OBRA) was enacted in 1987, it was viewed as the most sweeping piece of nursing home legislation in the history of regulation. It addressed a multitude of changes that underscored how nursing home residents were persons entitled to individualized care, and it promoted their “highest practicable physical, mental and psycho-social well-being.”

Groundbreaking at the time, among OBRA’s provisions were:

- Emphasis on a resident’s quality of life as well as the quality of care
- Expectations that each resident’s ability to walk, bathe and perform other activities of daily living would be maintained or improved
- Recognition of the need to conduct resident assessments to create individualized care plans
- Requirements for training for nurses aides
- The right of residents to be free from unnecessary and inappropriate physical and chemical restraints
- Definition of the roles and responsibilities of the State Long-Term Care Ombudsman for the

Commonwealth of Massachusetts

- Identification of new remedies to be applied to certified nursing homes that failed to meet minimum federal standards¹

This article will focus on the changes that OBRA has wrought — and what still remains to be done.

USING RESTRAINTS

In 1987, the long-term care industry was different than it is today, as was the average profile of a nursing home resident. Then, many more residents were ambulatory and needed supervision rather than skilled nursing care. Today, people who need only little assistance move into assisted-living residences, and advances in anesthesia and surgery mean that a post-hospital convalescence is often shorter than in the past.

Then, however, many nursing homes utilized both physical and chemical restraints in an effort to protect residents from injury. It was not uncommon to walk the halls of nursing homes and see residents sitting in chairs with either a vest restraint or a sheet tying them into the chair. Sadly, several cases of residents sliding down in their chairs and being strangled by the very restraints that were supposed to support them were reported each year.

At the time of the law’s passage, it made sense to prohibit the use of restraints and to find alterna-



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IN 1987, Susan McDonough was the long-term care ombudsman for the Commonwealth of Massachusetts, and Louise Clough recently had been hired by the Massachusetts Extended Care Federation to help the organization’s nursing home members implement the provisions of OBRA. From their respective vantage points, both professionals quickly recognized just how far-reaching the impact of this new law would be on residents’ quality of life as well as on how long-term care facilities operated. Now, 20 years later, McDonough and Clough are part of the senior management team at Covenant Health Systems.

tives that would be more beneficial and less restrictive to the residents. Inspired by OBRA's requirements, along with consumer and family demands, we have products such as alarms, slip-resistant pads for chairs, and special cushions that provide for safety and positioning without tying a resident to the chair. Further, not only has the definition of restraint been changed to include bed rails and other mechanisms, but nursing homes also report the number of people restrained and are required to demonstrate that any use of restraints is a last resort. It's typically used to either position or facilitate a resident's activities.

DEMENTIA CARE

As long-time advocates for those with dementia, we have witnessed incredible changes in the way that care is provided to those with Alzheimer's disease and other memory impairments.

While the Alzheimer's Association was in its nascent stage in 1987, many in the long-term care field still referred to people as having senile dementia, and it was considered a "normal" part of aging. For those residents who tended to wander or had disruptive behaviors, medication — including psychotropic medication — was a "reasonable" care plan.

In 1985, Massachusetts allowed the development of 10 demonstration units dedicated to Alzheimer's care. These were the beginning of the development of units that provided a supportive environment, were exit controlled, and offered a range of programs and services designed to provide Alzheimer's residents with a setting that was "habilitative."

Through the years, we've seen a marked decline in the type and frequency of psychotropic drugs administered for the sole purpose of managing disruptive behavior. However, unruly behaviors continue to be a challenge for many nursing home providers. The Centers for Medicare and Medicaid Services has continued this focus by having nursing homes report as part of the quality measures the frequency of psychotropic drug administration in the absence of a psychiatric diagnosis.

PATIENTS OR RESIDENTS?

As two people who struggled to understand what "highest practicable" level of functioning meant, we joined hundreds of people in the long-term care industry who tried innovative approaches that would respond to the needs of the people we serve.

One seemingly small, yet significant, issue had to do with nomenclature. Those served were originally called "patients," but the industry and consumers began to realize that we were creating long-term "homes" for people who needed care

and supervision. The term changed to "residents." With the continued evolution to provide short-stay recuperative care in skilled nursing facilities, however, many question if we should return to the term "patients" in order to reflect the needs of those we now serve.

MEASURING QUALITY

Throughout the evolution of the nursing home/long-term care/skilled-nursing care industry, the survey process has lagged in recognizing the need to measure outcomes rather than processes. In fairness to the regulators, measuring quality of life is difficult. And the more latitude or discretion placed in the hands of surveyors, the more the provider community points to fairness issues. Innovative providers, however, have engaged state surveyors in understanding their approaches to ensuring residents' quality of life prior to implementation and, for the most part, encountered support.

We must continue to work with others to support a long-term financing plan which relies less on Medicaid in the future and creates more options for older adults.

Among the standardized certification standards that OBRA imposed were nurse's aide training and the use of the Resident Assessment Instrument/MDS, which was first used for care planning and then for payment and quality measurement. More recently, nursing homes are required to post daily staffing levels, and to provide influenza and pneumococcal pneumonia vaccinations for all residents.

It is also appropriate to point out that not all providers "stepped up" and addressed these challenges in an appropriate manner. Some providers did not implement new changes because they "cost too much." Others, including some Catholic not-for-profit nursing homes, were slow to implement changes because of lack of time, ability to make decisions and, for a few, the existence of a paternalist attitude of "knowing better" than the resident.

MARKETING

Many of us remember the days when Catholic nursing homes had waiting lists of 100-plus people and you had to "know" someone to get in. As the marketplace has evolved, several Catholic nursing

home providers were shocked to learn that marketing services were necessary and that offering attractive environments, good quality of care, a customer service attitude and a spiritual atmosphere was the only way to keep the beds filled.

On the other hand, respecting the dignity of all persons, particularly those who are most vulnerable, has been the basis on which most Catholic nursing homes were established. The efforts to provide individualized care promulgated by OBRA was a natural extension of the teachings of the church.

COMPLIANCE AND ACCOUNTABILITY

Throughout the past 20 years, Congress has adopted a number of requirements that build on the central principles of OBRA. These requirements have created additional opportunities—and, in some instances, burdens—for providers.

For example, parts of the original law took years to put into a regulatory structure, causing frustration on the part of consumers, advocates and regulators. Congress continued, however, to adopt new requirements, including those calling for increased enforcement for poor-performing institutions and imposing civil monetary penalties for lack of compliance.

In 2000, CMS (formerly the Health Care Financing Administration), adopted requirements for nursing homes to report data and made it publicly available on Nursing Home Compare, which includes information only on nursing homes that Medicare or Medicaid certifies. As a result, it empowered consumers — potential residents and their families — to review quality and staffing data prior to selecting a facility.

OBRA SPURS INNOVATIVE PROGRAMS

Other initiatives that have resulted — even if indirectly — from the advent of OBRA are the Eden Alternative in 1991, the Pioneer Network in 1997 and, more recently, the whole “culture change movement.” In addition, the Medicare Quality Improvement Organization program’s Nursing Home Quality Initiative has expanded from clinical issues such as pain and pressure ulcer prevention to resident-centered care initiatives such as consistent staffing assignments. There also is the Advancing Excellence in America’s Nursing Home Campaign, a coalition-based effort which is reinvigorating efforts to improve the quality of care and quality of life for those living or recuperating in America’s nursing homes.

All of these programs have focused on efforts to deliver care which responds to the unique needs of the residents and to create environments that support older adults’ full potential. Each

program focuses on creating culture change in long-term care facilities, and also reflects the OBRA mandate to provide staff training. These programs also were critical to Catholic nursing home sponsors because they called for the empowerment of staff and creating supportive working environments, both of which are consistent with the teachings of the church regarding workers.

As many of Covenant’s long-term care facilities have embraced new ways of addressing our residents’ needs, we have adopted plans and programs by these organizations. For example, two of our facilities are Registered Eden Alternative Homes and actively pursue the ideals of this movement, which is based on the core belief that aging should be a continuing stage of development and growth, rather than a period of decline.

At St. Joseph’s Manor in Brockton, Mass., the administrator has stressed that Eden is more about the people than the building, and direct care staff are no longer called nurses’ aides but “associates,” reflecting their role in collectively achieving the residents’ highest quality of life and care. At St. Marguerite d’Youville Pavilion in Lewiston, Maine, building changes were made, including full kitchens in every resident dining room to enable family-style dining. At both locations, intensive and ongoing staff training continues to be an important factor in keeping the Eden journey on track.

TRANSPARENCY IN NURSING HOME CARE

OBRA provided the initial framework for transparency in nursing home care, an effort that is now being replicated in hospitals throughout the country at Medicare’s mandate.

In addition to the public reporting of quality and staffing data mentioned earlier, OBRA called for residents to have a voice in how the nursing home was governed through either residents’ councils or family councils. It also established the role of the State Long-Term Care Ombudsman Program, which was specifically empowered to receive and address the problems and complaints of residents and their families. The complaints reported often went far beyond the scope of the regulatory agencies and encompassed issues related to family problems; resident-to-resident problems, and maintaining an environment that supported individual residents’ needs.

PALLIATIVE CARE

Palliative or hospice care has always been a hallmark of Catholic nursing homes. In past years, many people chose a Catholic nursing home because they knew that they would not die alone.

Today, we are at a crossroads. It is understandably difficult for many long-term care providers to determine the most appropriate path to take.

Today, this continues to be the practice in Catholic nursing homes, which have established protocols to provide the highest quality of palliative care.

Palliative care has evolved significantly in the past 20 years. All nursing homes are more sophisticated about pain management and other ways, including complementary medicine, to relieve suffering. Also, Catholic providers have focused on meeting the spiritual needs of all our residents, but particularly those who are at the end of their lives. We have long been impressed by the efforts of many staff in Catholic long-term care who have taken extraordinary steps to ensure that a resident has a “good death.”

ON THE HORIZON

One of the more recent movements gaining traction in the United States is the Green House model. Developed in a manner that reflects the principles of OBRA, it calls for the creation of home-like environments, including private rooms and baths, with a central area where residents and staff come together to support one another and address older adults' care needs in a very personalized approach. These settings usually house a small number of residents who are supported by consistent and committed caregivers trained as universal workers.

As this model is being implemented throughout the United States, it feels as if the long-term care industry has come full circle, arriving at a place where care is being delivered in a person's home, by their loved ones. Unfortunately, the regulation and financing available for long-term care in most states creates a barrier to the development of these models.

Further, Catholic nursing homes in particular may be very interested in the model, but many are tied to large buildings that are difficult and expensive to adapt. We must continue to work with others to support a long-term financing plan which relies less on Medicaid in the future and creates more options for older adults.

AT A CROSSROADS

Looking back, it was hard to imagine the impact of OBRA on what long-term care looks like today. It was a watershed piece of legislation that made long-term care much more resident-focused, and able to adapt to changing consumer needs.

Today, we are at a crossroads. It is understandably difficult for many long-term care providers to determine the most appropriate path to take. On one hand, we are called to provide resident-centered care, home-like environments and well-trained and engaged staff. On the other hand, because of ongoing Medicare requirements, long-term care is seeing an increase in the number of people coming to us for recuperative care, a population that often has different care and amenity needs from the long-stay populations.

In order to continue to sustain our healing ministry, Catholic long-term care providers must continue to evolve, take risks, innovate and make each dollar go a long way. Plus, dignity of the individual must remain central to our activities. The same challenges facing the original sponsors of Catholic nursing homes remain today. We've truly come full circle. ■

NOTE

1. OBRA '87 — Federal Nursing Home Reform Act from the Omnibus Budget Reconciliation Act of 1987 or Simply OBRA '87 Summary — Developed by Hollis Turnham, Esq. — National Long Term Care Ombudsman Resource Center, www.ltombudsman.org.