OBRA '87
Has It Resulted in Better Quality of Care?

This study examines perspectives of a broad group of nursing home employees, regulators, advocates, and professional associations to describe progress made since the 1990 implementation of the Nursing Home Reform legislation (OBRA '87) and to determine whether the legislation is perceived as affecting positive change for nursing home residents. Interviews were conducted with 59 residents and 132 professional and non-professional staff in six states. Important quality of care issues of resident rights, resident dignity, restraint use, resident assessment, as well as perspectives of residents themselves are explored. In general, OBRA '87 is viewed as positive, with all groups of respondents indicating that residents have benefited from it. They identify the focus on resident rights as the most important accomplishment. Empowerment of residents through involvement in care decisions is noted by many as an important achievement. Many conclude that quality of care has improved and restraint use has decreased. The MDS is a useful tool from the standpoint of nursing home staff and regulators. This appraisal sharply contrasts their opinions about the Preadmission Screening and Resident Review (PASARR) screening tool. We believe that PASARR should be reexamined and that changes should be made in the process and/or implementation of the tool.

The Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) mandated the most comprehensive legislative requirements ever to affect nursing homes and the delivery of long-term care to the 1.5 million residents of nursing homes. The intent of OBRA '87 was to improve quality of care in nursing homes through establishing a single set of conditions for certification of all nursing homes. The phasing in of regulations dealing with resident care, rights, behaviors, quality of life, interdisciplinary evaluation, staffing requirements, facility practices, and other factors began on October 1, 1990 (Department of Health and Human Services, 1989).

Significant problems with OBRA '87 were identified early on in its development by nursing home providers as well as advocates. Nonetheless, the Act was approved, mandating major changes in the industry without funding the changes. Regulations for implementing the Act were late in arrival and heavily contested, in part, because the industry was required to make major changes without having access to government loans or other assistance. The regulations were pub-
lished in November of 1994, seven years after passage of the Act and four years after implementation was mandated. Serious questions have been raised about how successful the implementation of the legislation has been and whether the rules and methods for carrying them out are bringing about a positive change in long-term care in the most effective way. Because of these concerns, this study examined perspectives of a broad group of nursing home employees, regulators, advocates, professional associations and nursing home residents on the effect of the OBRA '87 legislation on nursing home care. Specifically, the aims of this research were to describe perceptions of progress made since implementation of OBRA '87 in 1990; to identify administrative, financial, medical, and nursing issues associated with implementation of OBRA '87; and to determine whether implementation of these regulations to date is perceived as affecting positive change for nursing home residents. In this article, important quality of care issues of resident rights, resident dignity, restraint use, resident assessment, as well as perspectives of residents themselves will be presented.

**METHODS**

**Setting**

To obtain a wide geographical representation, six states: New Jersey, Louisiana, North Dakota, Washington, New Hampshire and Oklahoma, were selected after advice from representatives of the Health Care Financing Administration (HCFA), the National Citizens Coalition for Nursing Home Reform (NCCNHR) and national consultants. States where national studies were being conducted by HCFA were excluded to prevent bias as a result of more intensive education.

Eighteen Medicaid and Medicare certified, state-licensed nursing homes, three in each state, were carefully selected for inclusion in this study. Facilities located in urban, suburban, and rural locales, were selected using the national ratio of two proprietary to one non-profit nursing home and ranged in size from 50 to 280 beds with a mean census of 124 (Table 1).

**Subjects**

Within each state, interviews were conducted with government officials, including federal and state nursing home surveyors and supervisors and state reimbursement officials and ombudsmen; executive directors of both the proprietary and non-profit professional associations; and professional organizations representing nursing, medicine, social work and advocacy groups. Interviews were also conducted in each nursing home with the Administrator, Director of Nursing (DON), a licensed nurse, a certified nursing assistant (CNA) and three residents. A total of 132 interviews were conducted with professional and non-professional staff (Table 2). A total of 59 residents were interviewed. Care was taken to assure that those interviewed were involved in nursing homes both pre- and post-OBRA '87 implementation. Only nine individuals were not involved with nursing homes prior to 1990 (5 nursing home employees, 3 regulators, 1 resident).

**Procedure**

A structured and open-ended interview guide, first developed in a pilot study conducted in 1992 and revised, was used for all interviews.
TABLE 3
Most Frequently Cited Examples of Changes in the Quality of Care Since Implementation of OBRA '87 (N=132)

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination of restraints</td>
<td>49</td>
</tr>
<tr>
<td>Improvement in resident rights</td>
<td>37</td>
</tr>
<tr>
<td>Shift from provider-driven care to resident-driven care</td>
<td>33</td>
</tr>
<tr>
<td>No change related to OBRA '87</td>
<td>31</td>
</tr>
<tr>
<td>Increased continuity of care</td>
<td>28</td>
</tr>
<tr>
<td>Decrease in chemical restraints</td>
<td>25</td>
</tr>
<tr>
<td>Increased emphasis on restoring mobility and function</td>
<td>22</td>
</tr>
<tr>
<td>Better planning and assessment</td>
<td>14</td>
</tr>
<tr>
<td>Increased paperwork</td>
<td>12</td>
</tr>
<tr>
<td>Increased communication with family</td>
<td>10</td>
</tr>
</tbody>
</table>

(Fagin, 1994). The interview guide was reviewed and revised by an expert panel, including a geriatrician, gerontological nurse practitioner, federal regulator, statistician, and sociologist specializing in gerontological research.

The interview consisted of 27 items, several of which were followed by open-ended questions or additional statements requiring a categorical or scalar response. Interviews lasted at least one hour, and respondents were encouraged to freely comment on items. Certain questions were designed only for government officials. These questions related to the effectiveness of the state survey process, including types of deficiencies currently and prior to OBRA '87, regulatory agency actions taken in response to deficiencies and waivers for Registered Nurses (RNs). Other questions were asked only of nursing home staff and included identifying Licensed Practical Nurse (LPN) and RN staffing changes, the creation of any new nursing roles and personnel training needs since implementation of OBRA '87. All other items were answered by all respondents and targeted effectiveness of the Minimum Data Set (MDS) assessment instrument, the Preadmission Screening and Resident Review (PASARR) process, the OBRA '87 guidelines, the survey and enforcement process, promotion of resident rights, especially restraint use and quality of care, and competence of nursing home staff.

The resident interview consisted of 18 items and was designed to last no more than 30 minutes. This instrument was also reviewed by a panel of experts for content and pilot tested prior to use to assure interrater reliability. Items centered on resident knowledge of OBRA '87, new regulations and perceptions of change in areas of resident rights, quality of care, competence of staff, resident and family involvement in care planning, presence of support groups, and the survey process.

Data Analyses

Responses were separated into five groups: nursing home staff, state regulators/supervisors of reimbursement processes, resident advocates, professional organizations, and residents. Frequency tables were constructed for the categorical and scalar items based on these groups then totaled for composite analysis of all respondents. Due to the different question structure for the resident interview, resident responses were analyzed separately. Responses to open-ended questions were analyzed using content analysis (Miles & Huberman, 1994). Composite results of all non-resident participants (n=132) and resident perspectives (n=59) are reported in this article.

RESULTS

Quality of Care

The most common responses related to changes in the quality of care were a decrease in the use of restraints and improvement in resident rights with a new emphasis on resident-driven rather than provider-driven care (Table 3). The assessment process was specifically cited by non-resident participants as improving identification of priority problems and facilitation of problem-solving for residents.

Although the majority of the responses were positive, 31 participants responded that there was either no change or minimal change in quality of care as a result of OBRA '87. Twelve participants noted a burden of greater paperwork demands, which they felt detracted from quali-
Quality of care. In addition, four participants cited problems with OBRA ’87 related to the mentally ill, mentally retarded, and/or confused residents. Other specific deficits in care as a result of OBRA ’87 noted by individual participants included high workloads and greater stress for staff because of the reduction in restraint use and a belief that the regulations were unrealistic and staff were trying to do the “impossible.” There were six negative comments by respondents who believed only marginal improvement was achieved and that the facilities that were substandard before OBRA ’87 remained substandard.

Fifteen participants believed that an increase in the quality of care was directly related to an increase in both the education and competence of staff. Nine of these fifteen participants were care providers. An increase in multidisciplinary collaboration was identified by three participants and three others noted that increased numbers of staff facilitated quality care.

### Quality of Life

In OBRA ’87 provisions were made for services that promote maintenance and enhancement of the quality of life of each resident. Specific aspects of quality of life identified in the survey process were resident dignity, resident rights, and use of both physical and chemical restraints.

**Resident Dignity**—A greater focus on the dignity of the resident was frequently identified as respondents referred to dignity in various ways. When asked about changes in quality of care since OBRA ’87, 33 participants identified a shift to resident-driven care rather than the traditional provider-driven care (Table 3). Resident-driven care was characterized as providing a more “humane” environment with a focus on the quality of life of residents rather than custodial care. Thirty participants identified the greater emphasis on the resident as a unique individual as one of the general merits of OBRA ’87.

**Resident Rights**—When all respondents were asked to identify changes in the quality of care since the implementation of OBRA ’87, improvement in resident rights was the most frequent response. In the new law, residents are to be provided the right to be fully informed in advance and participate in decisions about care and services or changes in care and services (NCCNHR, 1991). A total of 120 of the 132 respondents identified improvement in residents’ rights (Table 4).

In addition, 90 of the 132 individuals provided additional comments which included that the resident was now listened to more and was asked to be more involved in resident councils. In other words, staff had changed their attitude toward residents. Another 17 participants noted that there were changes in resident attitude and behavior. These participants believed that residents were now speaking up and becoming more assertive, as well as filing complaints about questionable care. Other participants noted that the staff were better educated about resident rights (n=10).

There were several comments that were neutral or even negative. Three participants stated that their agencies were always supportive of resident rights, but that the paperwork was now more reflective of practice as a result of OBRA ’87. Others worried that the regulations about rights were “too much,” citing difficulty in decision-making when someone was “dying.”

**Physical Restraints**—One key aspect of OBRA ’87 is the provision related to physical and chemical restraint use. In the law, residents have the right to be “free from...any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident’s medical symptoms” (Department of Health and Human Services, 1989).

A total of 96% (126) of the 132 respondents reported improvements in use of physical restraints (Table 4). In addition, 82 participants provided additional comments in which 70 clearly identified a reduction in physical restraint use. There were four dissenting voices that believed the new regulations often placed

### TABLE 4

<table>
<thead>
<tr>
<th>Area of Care</th>
<th>Deteriorated</th>
<th>No Change</th>
<th>Improved</th>
<th>No Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Rights</td>
<td>0</td>
<td>12</td>
<td>120</td>
<td>0</td>
</tr>
<tr>
<td>Physical Restraints</td>
<td>1</td>
<td>3</td>
<td>126</td>
<td>2</td>
</tr>
<tr>
<td>Chemical Restraints</td>
<td>2</td>
<td>14</td>
<td>112</td>
<td>4</td>
</tr>
</tbody>
</table>
Serious questions have been raised about how successful the implementation of the legislation has been and whether the rules and methods for carrying them out are bringing about a positive change in long-term care in the most effective way.

facilities in a "catch-22" where they were held accountable for safety and yet unable to use restraints.

Chemical Restraints—Improvement in the use of chemical restraints was identified by 85% (112) of the respondents (Table 4). In addition, 72 respondents provided additional comments that included 40 who identified a decrease in the use of chemical restraints. Another 15 expanded their responses by indicating the alternatives being used in the place of chemical restraints such as occupational therapy, physical therapy, increased activities, and ambulation.

Nine participants noted that medications were used more effectively and reviewed more frequently, while another six identified an overall increase in awareness of appropriate use of chemical restraints. Twelve participants stated that while some improvement had been initiated in the area of chemical restraints it was not enough. Three participants questioned the benefit of decreasing chemical restraints as they were fearful that residents may harm themselves if not properly sedated. Seven participants identified restraints as an old problem that had been resolved before implementation of OBRA '87.

Resident Assessment—In order to improve the quality of care provided, OBRA '87 mandated a comprehensive resident assessment to serve as the foundation of resident planning and delivery of care. The Resident Assessment Instrument consists of two parts: the Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs). In addition, a pre-admission screening and annual resident review (PASARR) was implemented to prevent mentally ill and mentally retarded persons in need of intensive mental health treatment from living in nursing homes, assuming they can receive better services from another setting (NCCNHR, 1991).

Minimum Data Set—The MDS consists of federally required core elements and common definitions for resident assessment. It contains triggers that cue the users to areas requiring more in-depth assessment. The MDS was identified as the most helpful tool of OBRA '87 with 73% (96/132) of the participants indicating improvement in this area. The MDS was often described as helping to give more of a "whole picture" of the resident, for baseline as well as ongoing assessment.

Generally an RN was identified as the coordinator of the MDS by 58 participants, although nurse administrators also served as coordinators in some states. Directors of nursing were identified as the MDS coordinator by 35 participants and Assistant Directors of Nursing were identified as coordinators by 21 participants. Although nurses served as coordinators, most disciplines were involved in the completion of the MDS. Registered nurses, LPNs, activity therapists, dietitians, social workers, and outside consultants were identified by participants as being involved with the MDS completion.

Sixty-two participants gave qualitative comments/examples related to the MDS. Besides the benefit of giving a "whole picture" of the resident, comments indicated that the staff now know the residents better, and that it "forces" improved assessment, which ultimately improves patient care. Care providers often cited the practical aspects of giving better quality care to residents, while administrators, advocates, and regulators cited the importance of having a universal assessment tool that could be utilized across settings.

Resident Assessment Protocols—The RAPs provide additional assessment items and background information to guide the users in identification of the resident's strengths, preferences and needs which are then linked to care plan options (NCCNHR, 1991). A majority of the participants (86/132) reported improvement with the implementation of the RAPs. Although ten participants indicated that the protocols structured care and made "major improvements," others were hesitant about supporting its use. Participants perceived the idea of protocols to be good but not necessarily functional nor easily
implemented. In addition, they did not believe that long-term care facilities could be held accountable for this process. Three participants cited the RAPs as an improvement but added it was better because they "had nothing before." Other individual responses included that it may be "duplicative" of the MDS, and that is was just "not applicable."

PASARR—In contrast to a majority of support for the MDS and RAPs, participants were generally not supportive of PASARR. When participants were asked if PASARR should be changed, 49% of the participants responded yes and 58% noted problems with PASARR. A total of 102 participants provided further comments related to PASARR. Most comments were that either PASARR should be changed (34 suggested this) or abolished (28 suggested this). Those who favored changing PASARR were predominantly care providers (31 of the 34). The most predominant group calling for abolition was administrators (6 of the 34) and directors of nursing (6 of the 34).

Twelve participants recommended alternatives to the use of PASARR such as providing an off-site service for mentally impaired or mentally retarded residents and/or utilizing personnel to better serve the residents involved. Other suggestions included maintaining the initial screening but eliminate annual reviews, streamlining the process and/or eliminate medical diagnosis as the key indicator. One participant commented that PASARR may even discriminate against residents, as they may not get back in, once they are "treated" at a more appropriate center. Residents can be uprooted from a place they have lived for a long time.

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Residents' Perspectives

A prime focus of OBRA '87 was to increase resident knowledge of and involvement in the survey process and planning of their care. Therefore, resident interviews focused on these areas. Ninety-eight percent of the 59 residents interviewed resided in the nursing home prior to implementation of OBRA '87. Residents were asked if they were aware of new regulations the nursing home must meet; only 12% were aware of these new regulations.

When asked specific questions about changes in the survey process or about specific quality of care issues, residents overwhelmingly said they were unaware or had not noticed any changes. However, there were a few exceptions. Twenty percent of the residents did note an improvement in physical restraint use and 20% noted an improvement in the general quality of care. Fifty-three percent noticed that when state surveyors inspect the nursing home the surveyors talk with them or other residents. Thirty-one percent said the nursing home involved them in planning their own care and 76% were aware that the nursing home provided formal resident and formal family support groups at the nursing home.

DISCUSSION

Overall, non-resident respondents identified an improvement in the resident quality of life following implementation of OBRA '87. According to these respondents, greater attention to resident rights and dignity has been achieved and both physical and chemical restraint use has declined. In addition, the MDS and RAPs were well-received by respondents as useful tools in resident assessment. In contrast, PASARR has not worked as a screening tool and should be reexamined.

It is apparent from respondents that nursing home providers and caregivers took the implementation of OBRA '87 seriously and focused resources and effort to meet the intentions of the legislation. Other studies have had similar findings, especially those measuring the effect of restraint reduction efforts. Strumpf, Evans, and Schwartz (1990) and Gerber-Eigsti and Vrooman (1992) reported beginning efforts of some nursing homes to become restraint-free environments. Rader, Semradek, McKen-
Besides the benefit of giving a "whole picture" of the resident, comments indicated that the staff now know the residents better, and that it "forces" improved assessment, which ultimately improves patient care.

zie and McMahon (1992) implemented a statewide effort in Oregon to achieve the same end. Other states such as New York report major reductions in restraint use statewide (Janelli, Kanski, & Neary, 1994). An important finding of their study is that restraint reduction was accomplished largely without an increase in staff. Providers were very concerned that to implement restraint reduction programs major increases in staff would be needed.

Although OBRA '87 made many regulatory changes targeted to improve the quality of care, provisions for improving reimbursement to increase staffing to provide more care were not included. The law does require that a licensed nurse be on duty at all times and at least 8 of the 24 hours this nurse must be an RN. Many are concerned that the OBRA '87 licensed nurse requirements did not go far enough in protecting residents as well as nurses (Francesc & Mohler, 1994).

Staffing issues aside, positive effects for residents and the development of care alternatives to physical restraints have been reported (Werner, Korokny, Braun, & Cohen-Mansfield, 1994). Adverse effects of releasing restraints such as falls have been examined; while an increased incidence of falls following releasing restraints has been reported, serious falls did not increase (Ejaz, Jones, & Rose, 1994).

The reported reduction by participants of chemical restraint use in this study also has support in the research literature. A substantial decrease in antipsychotic drug use was documented in nursing homes in Tennessee during a 30-month window surrounding the implementation of the OBRA '87 regulations designed to reduce unnecessary drug use (Shorr, Fought, & Ray, 1994). Some nursing homes reduced antipsychotic drug use by 41% without substitution of other psychotropic drugs. These changes are consistent with the legislative intent.

The problems cited by respondents with the PASARR were suggested as potential problems by authors early in the OBRA '87 implementation process. It was made clear that candidates for nursing homes cannot be admitted if they are only mentally ill or retarded; they must require nursing care and a state agency must review their cases and approve admission (Gallo, Katz, Levenson, & Scherger, 1991). Warning that OBRA '87 could cause problems similar to those that occurred following the deinstitutionalization movement, mental health professionals advise that there is great potential for creating homelessness and continuing to fail to serve persons with serious mental illness in the community (Avellone-Eichmann, Griffin, Lyons, Larson, & Finkel, 1992). The PASARR should be carefully reexamined and revisited to assure potential residents who could benefit from nursing home services are not denied access simply based on their history of mental illness or mental retardation.

Considering residents' points of view, it is interesting that of all the changes initiated by OBRA '87 restraint reduction efforts were visible enough to be detected by residents. From the perspective of many residents physical restraint use had improved. This is an important finding. Residents are frequently fearful of being "tied down" (Evans & Shrump, 1990). The perspective that physical restraints may be used more judiciously could be reassuring to those residents who are aware of their surroundings and fear restrictions imposed by restraints.

Resident awareness of formal support groups for residents and families could be a tangible reflection of resident-driven care rather than provider-driven care. It is a positive shift in focus and it is positive to see residents are aware of available support systems. It is important that studies of nursing home care quality include resident perspectives. Without their point of view to validate what has occurred in the setting, the result of many good intentions could be anything but what was intended.

SUMMARY AND CONCLUSIONS

One hundred and thirty-two nursing home employees, advocates, representatives of professional associations, and government officials
It is apparent from respondents that nursing home providers and caregivers took the implementation of OBRA '87 seriously and focused resources and effort to meet the intentions of the legislation.

Optimism among those interviewed. They believe that progress has been made to improve the quality of care residents receive. It is apparent that the central intent of OBRA '87 to focus on residents, their rights, care and dignity has begun to be realized.

REFERENCES


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QUALITY OF CARE KEYPOINTS


1. Post-OBRA implementation, the focus of care has shifted from provider-driven to resident-driven.

2. The MDS is a useful tool providing a more comprehensive perspective of patient care.

3. Implementation of PASARR has been problematic and should be re-examined.

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