SA22- Urinary and Fecal Incontinence: What to do About it in PA/LTC

Saturday, March 24
4:00 PM- 5:30 PM

Session Description

This session will discuss the epidemiology, classification, risk factors, and pathophysiology of urinary incontinence (UI) and fecal incontinence (FI) in persons living in the PA/LTC environment. The talk will cover evidence-based recommendations for assessment, treatment, and management of these conditions within the framework of patient-centered goals of care in PA/LTC.

Pharmacologic and non-pharmacologic treatment strategies will be reviewed. Psychosocial implications of UI and FI and the importance of patient-provider communication will be highlighted. Interactive case-based scenarios will be utilized. Innovative and emerging treatment techniques such as tibial neuromodulation and a patient-learning community research project will also be presented.

Learning Objectives

Describe the epidemiology, risk factors, classification, and pathophysiology of urinary and fecal incontinence in the PA/LTC environment.

Discuss evidence-based recommendations for the assessment of urinary and fecal incontinence in the context of patient-centered care in PA/LTC.

List pharmacologic and non-pharmacologic treatment strategies for urinary and fecal incontinence in older adults in the PA/LTC continuum.

Describe patient-oriented goals of care for the interprofessional management and improvement of quality of life for persons with urinary and fecal incontinence in PA/LTC.

Presenter(s): Kenya Rivas Valesquez, MD, CMD; Elizabeth Hames, DO, CMD; Michael Felver, MD; Suzanne Nall, RN, LNHA

Presenter(s) Disclosures: All speakers have reported they have no relevant financial relationships to disclose.
Urinary and Fecal Incontinence: What to do About it in PA/LTC

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Michael Felver, MD
Suzanne Nall, RN, LNHA

Speaker Disclosures
Drs. Hames, Rivas and Felver and Ms. Nall have no financial relationship(s).

Learning Objectives
By the end of the session, participants will be able to:
• Describe the epidemiology, risk factors, classification, and pathophysiology of urinary and fecal incontinence in the PA/LTC environment
• Understand evidence-based recommendations for the assessment of urinary and fecal incontinence in the context of patient-centered care in PA/LTC
• List pharmacologic and non-pharmacologic treatment strategies for urinary and fecal incontinence in older adults in the PA/LTC continuum
• Describe patient-oriented goals of care for the interprofessional management and improvement of quality of life for persons with urinary and fecal incontinence in PA/LTC

Urinary Incontinence
What to do about it in PA/LTC

MICHAEL FELVER, MD
SUZANNE NALL, RN, LNHA

Presentation Outline
- Discuss the scope of the problem of urinary incontinence in the PA/LTC environment.
- Identify the types of urinary incontinence and evidence-based recommendations for its assessment.
- Outline treatment strategies for urinary incontinence.
- Describe one facility’s approach to the problem of urinary incontinence.
- Assess the impact of implementing a novel treatment strategy using neuromodulation.

Scope of the problem for PA/LTC

CMS
According to the CMS/680 regulations, greater than 50% of the nursing home population experience some degree of urinary incontinence. 1

AMDA
According to the AMDA urinary incontinence guidelines, greater than 90% of long-term care residents suffer from urinary incontinence. 2, 3

CDC
According to the Centers for Disease Control, 30% of all long-term residents are not in complete control of their bladders. Which reference 4
Impact of urinary incontinence

Falls
Skin Integrity
Sleep Disturbances (Nocturia)
Dignity
Urinary Tract Infections
Staff Time & Satisfaction

Falls are responsible for 70% of accidental deaths in persons age 75 years and older.6

60% of nursing home residents fall each year.5

55-75% Turnover rates for RNs, LVNs & CNAs in nursing homes.6

Causes of urinary incontinence

- Stress incontinence
- Urge incontinence and overactive bladder (OAB)
- Overflow incontinence
- Functional incontinence
- Mixed types

Comparison of Principal Types of Urinary Incontinence

<table>
<thead>
<tr>
<th>Stress Incontinence</th>
<th>Urge Incontinence and OAB</th>
<th>Overflow Incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic relaxation</td>
<td>Detrusor dysfunction</td>
<td>Neuromuscular causes</td>
</tr>
<tr>
<td>Primarily in women</td>
<td>Principal risk factor is age</td>
<td>More common in men</td>
</tr>
<tr>
<td>Bladder leakage occurs with change in intraabdominal pressure</td>
<td>Characterized by involuntary leakage typically associated with urgency</td>
<td></td>
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</tbody>
</table>

Diagnosis of Urinary Incontinence

- Voiding history is best
- Determine whether of recent onset or chronic
- Clues from MDS
- Consider UFI
- Medication review
- Consider PVR

Treatment Strategies for Overflow Incontinence

1. Temporary catheterization
2. Alpha antagonists
3. Intermitent catheterization
Treatment Strategies for Chronic Stress and Urge Incontinence

1. Treat modifiable risks
   - Smoking, obesity
   - Alcohol, opioid rehabilitation
2. Toileting regimen
3. Pelvic and bladder rehabilitation
4. Antimuscarinics
5. Beta-3 Agonist
6. Neuromodulation (PTNM/implantable device)

PTNM Explained

- A MINIMALLY INVASIVE FORM OF NEUROMODULATION
- In use since 2005
- Percutaneously delivered electrical impulse via 34-ga needle
- Outpatient weekly induction treatments for 12 weeks, then monthly treatments for maintenance

Clinical Trials of PTNM

- **ORBIT Trial (2009)**
  - RCT of PTNM vs. tolterodine LA in 100 patients
  - Significantly higher on the Incontinence Impact Questionnaire in both arms
- **SUmiT Trial (2010)**
  - RCT of PTNM vs. sham in 220 patients
  - Statistically significant improvements in OAB symptoms vs. sham
  - After 12 weeks, patients showed a 90% reduction in incontinence and a 20% reduction of urgency
- **STEP Trial (2012)**
  - Examined persistence of PTNM effectiveness in 50 patients
  - SUmiT responders continued PTNM for an additional 24 months
  - Statistically significant improvements in OAB symptoms persisted through 24 months

Impact of urinary incontinence

- **Quality Measures**
  - More than 1/3 of long-term residents are incontinent
  - The annual cost of managing urinary incontinence in long-term care facilities is $5.3B
- **Costs**
  - Lower star ratings may lead to lower reimbursement
- **Reimbursement**
  - Improving care planning for urinary incontinence can help meet QAPI plans
- **QAPI**
  - “Each resident who is incontinent of urine is provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible.”
  - “Urinary incontinence is one of the most common conditions among patients residing in long-term care facilities...It can often be managed and modified, and in some cases, reversed...”
What our Doctors & NPs said...

- It is not even something I ask about as a part of patient history. I'll say 40% but I know it is higher because I never ask.

What our Nurses said...

- My priority is getting the right med to the right patient. Toileting & check & change get in the way, especially when all of the lights go on at once.

What our STNAs said...

- Anything to help with this would be helpful, it is the bulk of my day - toileting & check & change.

What our families said...

- I do the laundry 3 times per week for my Mom. We don't talk about it, I just change her clothes & bedding quietly. I don't want to embarrass her.

Most Importantly What Our Resident’s Had To Say...

- I don’t think I have incontinence. I wear 3 pads, a trash can liner, and don’t take my diuretic the day before an outing just in case. When I get up, I go all over.

- I would do anything to go to my granddaughter’s wedding. I do not want to embarrass her.

PINM Team

- Medical Director
- Executive Director
- Administrator
- Director of Nursing
- MDS Coordinator
- Physical Therapist

The Process

TREATMENT DELIVERY OPTIONS

<table>
<thead>
<tr>
<th>Physician/NP</th>
<th>Therapy</th>
<th>RN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider can assess for OAB</td>
<td>Physician/NP can assess for OAB</td>
<td>Physician/NP can assess for OAB</td>
</tr>
<tr>
<td>Provider would also deliver treatments</td>
<td>Therapy would deliver treatments</td>
<td>Therapy would deliver treatments</td>
</tr>
<tr>
<td>Provider can assess for treatment effectiveness at 6 &amp; 12 weeks &amp; then quarterly</td>
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<td>Provider can assess for OAB and deliver treatments with Physician overseeing NUFQ program in the building</td>
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Process Map for Therapy Delivery
Pilot Overview and Outcomes
THE VILLAGE AT MARYMOUNT

<table>
<thead>
<tr>
<th>Patients Total</th>
<th>LTC Patients</th>
<th>ALF Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>29</td>
<td>19</td>
<td>10</td>
</tr>
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% LTC patients with + MDS change

46% ALF patients with + change

Average Monthly Call Lights

Review of 20,199 Patient Call Lights

20 patient population reviewed
Patients that had not completed 12 weeks of treatment were not included
Pre-treatment: an average/patient of 7.45 months of call light data was used
Post-treatment: an average/patient of 5.5 months of call light data was used

Potential Time Savings

23% reduction (20 patients reviewed)  Estimated 10 minutes of service time

6 call lights on average per patient per month  160 minutes per month = 2.6 hours per patient

640 Total Hours/Year = 0.3 FTEs

VSJ Case Study Observations

- NO bathroom related falls in 2016 or 2017 for ALF patients receiving treatment
- NO UTI/urinary related hospitalizations for NF & ALF population in 2016 & 2017
- NO change in the number of UTIs from 2016 & 2017 for NF
- MMP 11 UTIs in 2016, decreased to 3 in 2017. All of these patients were also on the 5 Healthcare water-based toileting program during this time period.

Presenter Contact Information

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Suzanne Nall (snall@marymounthcs.org)

References

7. https://www.medicare.gov/NursingHomeCompare/About/Long-Stay-Residents.html
Epidemiology of Fecal Incontinence (FI)

Studies possible underestimate the prevalence of FI as many patients are reluctant to report it.

Estimates vary depending upon the definition used and the study populations.

The prevalence of FI varies dramatically between NHs. It increases with age, particularly in the 8th decade and beyond. In the US, the prevalence is equal or greater in men than women.

The prevalence is 10% in community-dwelling older people >65 years of age and approximately 30% of nursing home residents.

In an observational study that included women aged 86 and 97 years, the prevalence of FI was higher among institutionalized or community-based women (14 vs 8%) than among non-institutionalized women (10 vs 5%).


PHYSIOLOGY

The external sphincter, puborectalis, and levator ani can be voluntarily contracted further to preserve continence.

If rectal contractions and the sensation of urgency generally subsides as the rectum accommodates to continued distension.

Thereafter, if socially convenient, the pelvic floor relaxes followed by defecation.

The external sphincter induces rectal contraction, the sensation of urgency, and reflex relaxation of the internal anal sphincter.

Mechanisms of preserving continence

continence
Normal anorectal sensation

Abnormal anorectal sensation

Reduced anorectal sensation

Increased anorectal sensation

Prolapse

Sphincter Atrophy

Nerve Damage

Dementia,

Obesity,

Smoking

Advanced age

Mobility impairment

Comorbid chronic diseases: diabetes, neurological disorders

Obesity, decreased physical activity

Female gender, anal sphincter trauma

Pelvic floor anatomical disturbances, rectal prolapse

The symptom of rectal urgency

Inappropriate cholecystectomy

Others

FI Subtypes

1. Fecal Incontinence: occurs when stool loss is abrupt. Primarily related to the anorectal dysfunction.

2. Overflow FI: secondary to constipation. Impaction = elevation of IAS tone.

3. Urgent FI: related to knowledge of rectal loss with inability to control. Primarily related to IAS dysfunction.

4. Stress FI: uncommon and associated with increased rectal anal gradient.

Evidence-based recommendations for the assessment of FI

There is a paucity of evidence on how to manage FI in older people with advanced dementia in nursing homes.

One of the most common causes of FI in the skilled nursing facility (SNF) population is constipation and final inspection with leakage of loose stool around the impaction.

Treatment should therefore address these strategies accordingly.

1. Evidence of the role of obesity in FI management is somewhat indirect and observational, and usually in the context of metabolic syndrome and other co-morbidities.
Evidence-based recommendations for the assessment of FI

1. Ongoing review of toileting patterns (optional: daily, weekly, or monthly) to determine if the resident had any incontinent episodes or not
2. Is there any specific toileting schedule that the resident usually follows?
3. Is there any particular toileting equipment or aids that the resident uses to manage incontinence?
4. Are there any underlying medical conditions or treatments that might affect the resident's ability to control FI?
5. Are there any psychological or behavioral factors that might contribute to FI?
6. Is there any family history of FI?

MINIMUM DATA SET (MDS)-Version 3.0
Resident Assessment and Care Screening
Nursing Home Comprehensive (NC) item set

Older resident must be classified in the category that best describes the resident

1. Always continent
2. Frequently continent (2 or more episodes of bladder incontinence, but at least one continent based measurement)
3. Continence (2 or more episodes of bladder based measurement)
4. Not rated, resident had an emergency or did not have a bladder measurement for the entire 7 days

Do you have a specific toileting schedule for managing the resident's bladder continence?
1. Yes
2. No

1. Yes

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Managing Fecal Incontinence in PALTC

Interprofessional Patient-Centered Management of Fecal Incontinence in PALTC

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Kiran C. Patel College of Osteopathic Medicine
Managing Fecal Incontinence in PALTC

### Treatment Options

<table>
<thead>
<tr>
<th>Non-surgical</th>
<th>Surgical</th>
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</thead>
<tbody>
<tr>
<td>Fiber supplementation</td>
<td>Anterior sagittal sacrocolpexy (ASS)</td>
</tr>
<tr>
<td>Bowel and bladder schedules</td>
<td>Vaginal colposuspension</td>
</tr>
<tr>
<td>Stool modifying drugs</td>
<td>Sphincteroplasty</td>
</tr>
<tr>
<td>Pelvic floor muscle training (PFMT)</td>
<td>Rectal prolapse repair</td>
</tr>
<tr>
<td>PFMT with biofeedback</td>
<td>Anal prolapse repair</td>
</tr>
<tr>
<td>Anal plugs (used in Europe, not in US)</td>
<td>Hemorrhoidectomy</td>
</tr>
<tr>
<td>Retime irrigation</td>
<td>Colostomy</td>
</tr>
<tr>
<td>Vaginal bowel control device</td>
<td>Artificial anal sphincter (AAS)</td>
</tr>
<tr>
<td>Bulking agent injections</td>
<td>Sacral nerve stimulation (SNS)</td>
</tr>
<tr>
<td>Tibial nerve stimulation</td>
<td>Vaginal sphincter replacement</td>
</tr>
</tbody>
</table>

### Pharmacologic Therapy

- First, avoid medications that may contribute to FI:
  - nitrates and calcium channel blockers - decreased sphincter tone
- Treat constipation - fiber, increased liquids, stool softener, 1 osmotic laxative, 1 rectal stimulant, weekly enema if needed - If that fails: manual disimpaction, water enema - 35% reduction of FI in one study
- Treat diarrhea - trial lactose free diet, bile salts (cholestyramine) if malabsorption, loperamide in moderation
- Anticholinergics - 7 decreases rectal contractions - ineffective
- Clonidine - 7 decreases rectal urgency (and sensation) - ineffective

### Surgery

- First, avoid medications that may contribute to FI:
  - nitrates and calcium channel blockers - decreased sphincter tone
- Treat constipation - fiber, increased liquids, stool softener, 1 osmotic laxative, 1 rectal stimulant, weekly enema if needed - If that fails: manual disimpaction, water enema - 35% reduction of FI in one study
- Treat diarrhea - trial lactose free diet, bile salts (cholestyramine) if malabsorption, loperamide in moderation
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- Clonidine - 7 decreases rectal urgency (and sensation) - ineffective

### Management Goals in PALTC

- Several clinical guidelines - ACG, ASCRS, NICE
- Treat underlying causes as appropriate
- Reduce symptoms
- Decrease frequency of episodes
- Decrease severity of episodes
- Improve quality of life
- Attention to patient-centered goals of care
Managing Fecal Incontinence in PALTC

Since 1966: Studies of FI in nursing homes (n=126) -- RCTs (n=2)

Schnelle and team – 2002, 2010

• 2002 – exercise, prompted toileting, increased fluids
  • significant reduction of FI frequency, UI frequency, fecal & urine toileting ratio, strength, and endurance
  • constipation remained a problem

• 2010 – exercise, toileting assistance, choice of food, fluid, and snacks
  • frequency of FI did not change (**45% in study had no BM at post-assess)
  • Significant improvement of food & fluid intake, frequency of toileting, physical activity,

Fecal Incontinence
Excluded: impaction
Treated: any diarrhea
Bowel regimen
Prompted voiding/defecation if ambulatory
Osmotic or stimulant laxative if non-ambulatory

Managing Fecal Incontinence: A Fecal Incontinence Patient-Learning Community

Buswell et al. JAMDA 2017
Realist review study in UK of 6 possible strategies to improve care for FI in persons with dementia in PALTC

6 strategies to improve care
1. Clinicians apportioning more time for patient assessment of FI
2. Educating staff on prompted voiding program (* protected staff time)
3. Focus on management of constipation - use laxatives in moderation
4. Individualized patient-centered care - cues and psychosocial support
5. Address staff perceptions about FI care and QI opportunities
6. Redistribution of staff time and possible addition of direct care personnel

Managing Fecal Incontinence: A Fecal Incontinence Patient-Learning Community

Nicole Cook, PhD, MPA and team - Nova Southeastern University
Fecal Incontinence in Primary Care Consortium (FIPC)
PCORI Tier 1 award

Year 1 - stakeholder group formed to define gaps in practice and research related to fecal incontinence
Year 2 - consortium formed to identify distinct research ideas
Tier 2 proposal - submitted

Some final thoughts:
Fecal Incontinence in PALTC

What is the role of patient-provider communication and trust on FI outcomes?
What is the comparative effectiveness of different educational programs targeting primary care providers and patients?
What is the comparative effectiveness of treatments for FI in primary care?
What strategies could improve screening for FI in primary care?
What would be the effects be in standardizing documentation of FI in the patient problem list?
References


Questions?