The New F-Tag 315

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In this issue, Johnson and Ouslander[1] tackle one of the most costly, enduring, and vexing problems in long-term care: urinary incontinence (UI) management. Since 1988 when a consensus statement on the state of the science was drafted by an interdisciplinary expert panel (National Institutes of Health Consensus Conference on UI) and in 1996, when the Agency for Healthcare Research and Quality (AHRQ, formerly AHCPR) published UI clinical practice guidelines, the dissemination and adoption of UI technologies has lagged well behind other geriatric syndrome initiatives such as fall prevention, restraint reduction, and pain assessment.[2,3] In their opening comments describing a symposium covering recent changes in the Centers for Medicare and Medicaid Services (CMS) guidelines for management of UI, the authors note with incredulity and alarm that among the 500 attendees, not one was a medical director or physician. Tempering this observation with the suggestion that this might be an isolated incident, they question whether medical directors in long-term care (LTC) have abdicated leadership in this domain of care. In this thoughtful and comprehensive paper, the authors describe the new CMS interpretive guidelines and their evidence base, and suggest how medical directors can fulfill new obligations related to the quality of care of residents with UI or catheters in the current LTC context that amplifies their leadership role in developing and implementing resident care policies and practices.

The new CMS guidelines combine former tags F-315 and F-316 into one (revised) tag, F-315, which contains interpretive guidelines, a new investigative protocol, and compliance and noncompliance criteria for residents with UI, urinary tract infection, or a urinary catheter.[4] As a certified continence care specialist, I approached this paper with great interest and expectancy. Johnson and Ouslander provide a succinct summary of the key recommendations in the CMS UI guideline and compare the guideline with other evidence-based guidelines from AHRQ and the American Medical Directors Association (AMDA), and quality indicators from the Assessing Care of Vulnerable Elders Study (ACOVE). They also provide Web links to direct the reader to the CMS site on the new UI guidelines, to view the original text, as well as other Clinical Practice Guideline (CPG) sites, and give directions on how to navigate. The authors provide a cogent summary of the current evidence for practice and concordance with other CPGs, and make recommendations for assessment, intervention, and monitoring. They make the point that despite the dissemination of UI guidelines, the quality of UI care has not measured up to standard. Few residents are appropriately assessed and few receive any treatment. In fact, in one study they cite, continence care was offered nearly as often (or as infrequently, as it were) as check-change: 1.0 assist and 1.3 assists per day, respectively.[5]

Johnson and Ouslander, both highly published and respected researchers and champions of UI management practices, provide a timely service to readers of the *Journal of the American Medical Directors Association* (JAMDA) by synthesizing the science base for current practice, demystifying the new interpretive guidelines, unbundling components of assessment and management to show where current capacity exists in facilities to implement UI care, and providing suggestions for the role of the medical director and primary health care providers (physicians, nurse practitioners, and physicians assistants).

To say that the new interpretive guidelines for management of UI have generated anxiety and concern among staff in LTC would be an understatement. The "punitive and antagonistic nature of the survey process" is a sentiment shared by many in this setting; some may even use terms like "capricious" and "irrational" to describe the survey process. Thus, in response to "innumerable critiques" of the survey process, CMS produced revisions to the UI regulations to provide "a more consistent, usable, and evidence-based approach to surveying nursing facilities." The intent of the new F-tag for UI is to provide clinically meaningful, evidence-based direction on UI assessment and management that better equips nursing homes to implement them and surveyors with a clearer set of evaluative methods and criteria.

Johnson and Ouslander provide evidence that few incontinent residents have documented UI assessments and summarize some of the key elements to incorporate into a general exam either on admission or in a subsequent, billable visit. These elements include, for example, a targeted physical exam (not specified), a rectal exam and superficial pelvic exam in women, a urinalysis, and postvoid residual urine measurement. Although not specifically mentioned, the assessment is often best accomplished with the help of nursing staff (particularly CNAs) who can provide more detailed resident information that can aide in the differential diagnosis. Surprisingly overlooked is the use of noninvasive portable ultrasound measurement of postvoid residual (PVR) urine measurement as an alternative to direct urethral catheterization, a technology that has been available for many years (BladderScan, Diagnostic Ultrasound Corporation, Bothell, WA). The importance of ruling out occult urine retention not detected by abdominal exam is especially important in residents with neurologic problems, on anti-cholinergic or

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narcotic drug therapy, in those who are postanesthesia or post–urinary catheterization, and in men with prostatic hyperplasia. The dangers associated with direct urinary catheterization such as urethral and bladder trauma, increased risk for urinary tract infection, and emotional distress (particularly in the cognitively impaired) are compelling in the frail elderly and is related to the low rate of PVR measurement. This technology has acceptable sensitivity and specificity and has numerous clinical applications in both assessment and treatment including bladder training, pharmacologic management of prostatic hyperplasia, and intermittent catheterizations following indwelling catheter removal.[6] The slow rate of diffusion of this technology in nursing homes, in contrast to hospitals and rehabilitation settings, may in part be because of its high cost; however, reimbursement mechanisms and leasing options should be considered as this technology could greatly improve the comfort and quality of care of incontinent residents.[6] In my experience using this technology, I have detected elevated PVRs in residents whom I would have clinically not expected this finding based on diagnoses, medical history, physical exam, medication list, and so forth, and the treatment plan was appropriately modified. Many clinicians are conservative in deciding which residents warrant PVR measurement via catheterization and thus there is risk of missing clinically significant urine retention.

Of practical significance, Johnson and Ouslander introduce the reader to the current nomenclature and evidence-based approaches for behavioral and pharmacologic treatment and management. Specifically, they provide a clear summary differentiating the toileting programs: bladder training, prompted voiding, habit training, and scheduled toileting. Misunderstandings about this nomenclature has been a barrier and hopefully the clarity of these descriptions, in this article and in the CMS guidelines, will help nursing home staff understand the significant differences between the toileting programs to more accurately target interventions to those who meet specific criteria and are most likely to respond. Regarding the intent of the guideline, CMS states, "Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible."[7] Unfortunately, CMS provides little guidance as to what constitutes therapeutic boundaries or stopping rules for toileting programs, or what is meant by ". . . as much normal urinary function as possible." For example, if residents are wet more than they are dry, is this sufficient evidence to discontinue a toileting program? The authors suggest identifying residents meeting certain criteria who are then matched with toileting interventions that would help them achieve "benefit." Targeting high responders for prompted voiding, for example, would direct scarce staff resources to residents mostly likely to benefit. Toileting programs as therapeutic intervention should meet some standard of efficacy and effectiveness. However, wetness/dryness standards are not specified in the CMS guidelines and this fuzzy area is sure to create apprehension and concern among nursing home staff. Does this compel staff to toilet (or say they will) most people if only once in awhile the resident actually voids in the commode? How wet does a resident need to be before a toileting program no longer has efficacy or effectiveness and can be stopped? Work by Schnelle and colleagues[5] set a high standard for permissible wetness rates (under 25%); a more liberal benchmark of 50% is adopted by others.[8] There is no clear guidance from CMS on continence benchmarks or stopping rules for toileting programs. These are decisions best made by informed clinical judgment of the medical and nursing staff based on the overall benefit to the resident, but exposure to surveyor interpretation/opinion leading to noncompliance citations makes this risky.

I would take issue with the authors' recommendation that the use of urge suppression techniques involving the use of pelvic floor muscles or pelvic floor muscle exercises (PFMEs) be deemphasized based on insufficient evidence. I would counter that there is a cohort in many nursing homes, for example where residents are admitted for a short stay for rehabilitation following acute incidents (CVA, hip fracture, infection, trauma, UTI, and so forth) and UI is either a new phenomenon or one that had not previously been evaluated. PFMEs and urge inhibition would not be inconsistent with current evidence in older adult populations and should be offered to residents who meet criteria and have the capacity to learn and replicate these behavioral techniques. I have worked with many nursing home residents on PFME programs and although small in number in proportion to the total nursing home population, the realized benefit was significant to the resident. The limiting factor is more due to inadequate knowledge of health professionals and technologies to properly assess and teach the techniques (and adapt them into nursing care routines) rather than a nursing home population that is altogether too aged or frail. The issue of holding nursing homes accountable for interventions such as these, when other settings of care are not held to such a standard, is certainly of concern. The availability of continence specialists to train staff is limited; as well as the availability of continence consulting services to provide direct care. Perhaps this will change with the new guidelines. In a review of translational research on incontinence practices, the use of advanced practice nurses improved care for incontinent nursing home residents.[9] There may be some lessons to be learned from other trials on adoption of JAMDA-authored CPGs for pain and falls in terms of training staff in new procedures.[10]

The authors' use of the term "diaper" gives a negative connotation to this management approach. I suggest removing the word "diaper" from the lexicon of UI management in favor of other more appropriately descriptive terms such as adult absorbent product, incontinence product, or adult pads or briefs. The CMS guidelines simply use "absorbent products." The label "diaper" is pejorative in that it confers unwarranted, negative connotations and does not do justice to the full range of specially designed adult products that can be very effective in helping residents maintain "social continence." The authors note that some residents prefer the use of adult absorbent products to other forms of management of UI even when other forms of treatment have shown effectiveness or the promise of effectiveness. In my experience, I have found this to be troubling but true. One could speculate on

the possible reasons for this personal preference and the authors note 2: treatment nihilism and showing deference to staff. I would add that receptivity to continence care options begin well before admission to the nursing home and is informed by the individuals' responses from health care professionals when they first recognize UI—maybe as a teen during athletics, a new mother postpartum, at midlife concurrent with hormonal changes, or as a consequence of comorbidities such as CVA. There are also issues of dysmobility and pain that often underlie resistance to continence interventions when, if effectively managed, would alleviate resistance. UI is a syndrome that should be approached not as a problem of the bladder primarily, but as a problem emanating from disconnects/defects in other systems or areas of function. In my experience as a continence specialist, patients still confess that they are told by their health provider when they report UI: "What do you expect at your age" or "There is not much that can be done other than surgery so try to just manage it." I still notice "blue pads" being put on the beds of new admissions even before their continence status is ascertained. There is much to be done in the area of both professional and consumer education about normal aging and UI.

Continence care has been deemed a costly intervention, in some ways implying that it is hopelessly beyond the reach of typical nursing homes strapped with increasing labor and supply costs and diminishing federal and state dollars. It is true that it is labor intensive. The authors report on randomized control trials that validate UI intervention benefit and patient preferences for this care but insufficient staff to implement programs consistently. While financial barriers are very real, there is a certain degree of hand wringing about cost that should be considered in light of research findings indicating that typical UI care is so minimal that *anything* you do above and beyond doing almost nothing will increase costs. That said, it is important to recognize the multifactorial benefits of a UI program. In addition to increased dryness, these benefits include promotion of mobility, range of motion, weight bearing, balance, skin integrity, bowel function, social interaction, and emotional well being. If a facility is actively implementing UI care, it is likely there are indicators of these other elements of good care. Getting nursing homes to invest in UI care requires incentives; the new CMS regulation being a powerful one. Johnson and Ouslander consider another strategy: that nursing homes market and promote UI services. They suggest that nursing homes should implement UI programs and use resident and family preferences for and satisfaction with this care to their market advantage. I concur that promoting UI care best practices could be quite successful since we know that many families struggle with UI care before deciding on nursing home placement, and furthermore, after admission, express a high degree of concern about UI care and vocalize distress if UI care is unsatisfactory. In one nursing home where the Duke School of Nursing implemented a comprehensive UI program collaboratively with staff, the director of nursing (DON) reported that family complaints on Monday mornings went from 20 to virtually none after implementing prompted voiding.[11] Families were ecstatic about the UI program. The DON said that the use of nurse aides designated for the prompted voiding program working 12 hours shifts 7 days a week ensured continuity of care and good outcomes. Additionally, these nurse aides recognized the restorative nature of their role and re-titled themselves "Quality Care CNAs," reflecting pride and ownership of the program. Focusing on evidence-based clinical services such as UI care would distinguish high-quality facilities and attract new admissions in competitive markets as well as garner community recognition.

An issue not mentioned in the article that bears noting is that of worker injury as a result of lifts and transfers and how this influences UI care, particularly in the context of increased obesity in the geriatric population. Until safe practices are in place to protect worker health, UI care will be stymied. There are currently a number of national initiatives under way and many facilities have adopted no-lift policies and have acquired specialized equipment for obese or dependent residents.[12] Special attention directed at employee welfare (training, monitoring, equipment) will increase the level of skill and self-efficacy among staff responsible for UI care and contribute to continuity of care.

A final consideration is the criteria for compliance and the determination of the scope and severity of noncompliance.[7] Negative outcomes are noted for each level, 1 through 4, when the nursing home has deficient practices. The authors do not address this area; however, this is likely to be of great interest to medical directors and nursing home staff given the penalties that are linked to these citations. Readers can easily access this information on the Web site but the matter of how surveyors will judge and interpret nursing home performance and how the penalties will be levied is unclear.

Although Johnson and Ouslander conclude that medical directors and other primary care providers have not involved themselves in UI systems of care in nursing homes, they provided suggestions to redress this by taking a greater leadership role in establishing programs for UI care. Clinically useful tools and training techniques for different levels of nursing home staff are desperately needed to ensure rapid and accurate application of UI best practices. One such resource is the Borun Center for Gerontological Research–sponsored quality improvement initiative, Urinary Incontinence Training Module, designed as a turn-key operation based on original research and field testing (Dr Ouslander is named on the site).[13] This resource provides a comprehensive array of UI assessment and quality-monitoring tools that can be downloaded and used. Resources such as this and other innovations such as use of advanced practice nurses as leaders in CPG implementation hold promise that evidence-based UI practices will be more readily adopted and sustained in the nursing home.[9,11]

It is widely quoted that it takes between 17 and 20 years for new knowledge to be diffused and adopted into practice. Johnson and Ouslander have provided an important contribution to the literature by providing a timely and comprehensive overview of the new F-Tag 315 for UI, urinary tract infection, and urinary catheter care. They offer practical strategies for medical directors and primary care providers to assume a greater leadership role in nursing homes to implement evidence-based practices within existing capacity.

There is promise that the new interpretive guidelines, investigative protocols, and compliance criteria will finally produce momentum for UI care that will have a lasting impact on the quality of care in nursing homes.

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