Outcomes of a physiotherapy-led pelvic health clinic

Author
Jackman, Amanda, Bongers, Mischa, Corcoran, Kristy, Nucifora, Jennifer, Weir, Kelly, Briffa, Kathy, Howard, Zara

Published
2018

Journal Title
Australian and New Zealand Continence Journal

Rights statement
© 2018 Australian + New Zealand Continence Journal. The attached file is reproduced here in accordance with the copyright policy of the publisher. Please refer to the journal's website for access to the definitive, published version.

Downloaded from
http://hdl.handle.net/10072/382536

Link to published version
https://search.informit.com.au/fullText;dn=621309184640141;res=IELNZC

Griffith Research Online
https://research-repository.griffith.edu.au
Outcomes of a physiotherapy-led pelvic health clinic

ABSTRACT
Allied health-led models of care have been shown to be effective in providing diagnostic evaluation and management of many health conditions, improved access to care, and reduced specialist outpatient waiting lists. An audit of a new physiotherapy-led pelvic health clinic for women on the urogynaecology waiting list was undertaken, from its inception in January 2017 until October 2017. The objective of this audit was to document the patient journey, clinical outcomes and patient satisfaction of 105 women who provided consent for their information to be included in the audit. Following the introduction of the physiotherapy-led clinic, participants reported shorter waiting times to attend appointments compared to the traditional medical model, improved clinical outcomes and high patient satisfaction. Many participants (65%) were discharged without requiring a urogynaecology specialist appointment. This audit supports the model of a physiotherapy-led pelvic health clinic as an effective model of care.

Keywords: Physiotherapy, urogynaecology, female urinary incontinence, pelvic organ prolapse, delivery of health care.

INTRODUCTION
Issues within the Australian health care system include a combination of medical specialist shortages, extensive waiting periods, and increasing financial strain. To address these issues, many health care services are introducing allied health-led primary health clinics, where appropriately triaged patients have access to treatments from an allied health professional in a timely manner, thereby reducing the wait time to treatment. This new model of care improves patient access and flow through health care pathways.

Physiotherapy advanced practice clinicians' diagnose conditions and triage care accordingly, providing timely treatment, maintaining high patient satisfaction rates, and reduce the number of medical consultant reviews required and associated costs. Physiotherapists are well placed to perform a lead clinic role as they are qualified to assess and treat across a range of generalist and specialised physiotherapy areas, including women's and pelvic health.

The purpose of this audit was to document the patient journey and clinical outcomes of women attending a pelvic health clinic led by physiotherapists.

Zara Howard *
Physiotherapist, Physiotherapy Department, Gold Coast Hospital and Health Service, Southport, Gold Coast, Qld, Australia
School of Physiotherapy and Exercise Science, Curtin University, Perth, WA, Australia
Email: Zara.Howard@health.qld.gov.au

Amanda Jackman
Physiotherapist, School of Physiotherapy and Exercise Science
Curtin University, Perth, WA, Australia

Mischa Bongers
Physiotherapist, School of Physiotherapy and Exercise Science
Curtin University, Perth, WA, Australia

Kristy Corcoran
Physiotherapist, School of Physiotherapy and Exercise Science
Curtin University, Perth, WA, Australia

Jennifer Nucifora
Physiotherapist, Physiotherapy Department, Gold Coast Hospital and Health Service, Southport, Gold Coast, Qld, Australia

Kelly A Weir
Allied Health Research Fellow, Allied Health Governance, Education and Research, Gold Coast Hospital and Health Service, Southport Gold Coast, Qld, Australia
Menzies Health Institute Queensland & Allied Health Sciences Griffith University, Gold Coast Campus, Qld, Australia

Kathy Briffa
Associate Professor, School of Physiotherapy and Exercise Science
Curtin University, Perth, WA, Australia

* Corresponding author

Competing interest statement
Three authors have declared they are employed by Gold Coast Hospital and Health Service in the physiotherapy department.
Conditions such as pelvic organ prolapse (POP) and urinary incontinence (UI) are associated with poor quality of life. It is estimated that 30% of women over 50 years old have symptoms of POP. Prevalence of UI is equally high, with incidence increasing with age. The pathophysiology of POP and UI is often multifactorial and includes pelvic floor muscle dysfunction, obstetric injury and lifestyle factors. The benefits of interventions provided by skilled physiotherapists for management of POP and UI have been well documented, and tailored treatment is recommended as the first-line treatment option. These benefits suggest that physiotherapy-led advanced practice clinics may be an efficient and effective way of providing care for women with POP and UI.

From 2014, Queensland Health (state government health department) began introducing physiotherapy-led pelvic health clinics (PLPHCs) to provide care to patients referred to colorectal, gynaecological, urogynaecological and urological services. Similar clinics in other states report improved access to physiotherapy as first-line treatment for UI/POP, compared to traditional medical models. In January 2017, a new PLPHC was established at Gold Coast Hospital and Health Service to better manage long waiting lists for urogynaecological patients. There is scarce literature assessing the effectiveness of PLPHCs; however, this audit provides an insight into the effectiveness of this model, to assist service planning and as a benchmark for future clinics.

**DESCRIPTION OF PLPHC**

The new PLPHC was geographically co-located with the urogynaecology outpatient service, allowing strong interdisciplinary flow between medical, nursing and physiotherapy services. After receiving a general practitioner (GP) referral for the urogynaecology clinic, patients were prioritised as ‘Category 1’ (urgent, specialist assessment <30 days), ‘Category 2’ (complex care, assess <90 days), and ‘Category 3’ (non-urgent, delayed assessment unlikely to lead to deterioration or a need for more complex care, assess <365 days). Only women from the urogynaecology Category 3 waitlist with conditions responsive to physiotherapy intervention were eligible for the PLPHC according to the following inclusion criteria: urinary frequency, urgency, and/or incontinence; and/or POP. Exclusion criteria were related to diagnosed conditions, abnormal results to investigations including: abnormal pap smear, swab, pelvic ultrasound or mid-stream urinalysis; and symptoms related to undiagnosed vaginal bleeding; genital tract fistulae; prolapse complicated by renal impairment or obstructed ureters; or previous continence physiotherapy for the condition (defined as a full course of physiotherapy completed in the last 12 months).

The clinic was staffed by two physiotherapists appointed as a clinical lead and senior physiotherapist. Both of these physiotherapists had a high level of clinical skill, knowledge and experience in women’s health physiotherapy. New patients were assessed by the clinical lead physiotherapist, who was responsible for developing the treatment plan and initiating referrals for investigation and/or escalating the patient for earlier urogynaecology medical review, as appropriate. All ongoing treatment and assessments were provided by the senior physiotherapist and options included pelvic floor muscle rehabilitation, lifestyle advice, and pessary fitting, as appropriate. At the completion of physiotherapy treatment, patients were discharged, either with or without urogynaecology medical review, as recommended by the physiotherapist or at the request of the patient, or for follow-up in a nurse-led pessary clinic. Patients who failed to attend the PLPHC were removed from the urogynaecology service in accordance with clinic policy and the patient and referring GP were informed.

At the inception of the PLPHC there was a backlog of patients on the urogynaecology waitlist who were appropriate for the PLPHC. To reduce the backlog, 72 patients were invited to attend a group education session for their first appointment and 53 accepted. These participants, who were diagnosed with POP or UI attended a 60- to 90-minute group education.
The education session included: an introduction to the PLPHC, information about relevant anatomy and physiology, information about common conditions, and self-management strategies such as activity modification, fluid advice, constipation management and weight loss. The POP participants attended their initial assessment immediately after their education session. The session for UI also included instruction on how to complete a bladder diary. For participants in this group, a bladder diary was required prior to their next appointment, scheduled one week after the education session. Once waitlists were reduced sufficiently, group education sessions were discontinued, and participants’ first PLPHC clinic visit reverted to ‘usual care’ with an individual consultation with the physiotherapist (Figure 2).

Australian Female Pelvic Floor Questionnaire (APFQ): Assesses all pelvic floor symptoms, dividing these into four domains: bladder, bowel, sexual function and prolapse. It has been validated for a patient-centred view of symptom severity, impact on quality of life and ‘bothersomeness’. Each section is scored out of 10 to get a dysfunction score, with higher scores indicating a greater level of disability. Total dysfunction score is the sum of the scores for the four domains and has a maximum of 40.

Assessment of Quality of Life-6D (AQOL-6D): Instrument designed to provide patient reported multidimensional evaluation of health-related quality of life. It has independent living, relationships, mental health, coping, and pain and senses dimensions. This tool was validated for the general Australian population.

Global Rating of Change Scale (GROC): Designed to quantify a patient’s self-perceived improvement or deterioration post-intervention using a numerical analogue scale. The scale ranges from –5 (very much worse) to +5 (completely recovered) with 0 being no change.

Patient Satisfaction Survey: Developed by Queensland Health, participants were asked to respond to eight questions indicating level of satisfaction regarding the PLPHC using a 5-point Likert scale. This ranged from very satisfied, scored as 1, to very dissatisfied, scored as 5. For the purpose of reporting, the scale was collapsed into two levels: satisfied, scored as 1 to 2 and less than satisfied, scored as 3 to 5. Overall satisfaction was indicated on a visual analogue scale consisting of a 100mm line. In addition, the survey included open-ended questions inviting further comments from the participants.

Health Professional Satisfaction Survey: Developed by the study investigators, the survey used a 5-point Likert Scale to assess health professionals’ satisfaction with elements of the PLPHC, with additional space inviting further comment.

**METHOD**

**Design**

This study was a post-inception audit of the PLPHC conducted in October 2017. It was approved by the Gold Coast Hospital and Health Service Human Research Ethics Committee (HREC/17/GGC/129) and Curtin University Human Research Ethics Committee (13545). It was a requirement of these committees that data could only be included from women who had provided written informed consent. The primary aim of the audit was to document the patient journey and clinical outcomes of women attending the PLPHC. A post-hoc comparison of the patient journey and clinical outcomes of women who attended the group education session with those who received ‘usual care’ at the PLPHC was also planned.

**Patient journey and clinical outcomes**

Patient journey data included: number of days from referral to commencement of clinical care, number of days from initial assessment to discharge, occasions of service, discharge information, referrals to other health professionals, referrals for investigations, use of pessary devices, discussion with medical consultant, adverse events, and patient satisfaction at completion of care within the PLPHC. All clinical data for the study were extracted from existing Queensland Health clinical/quality assurance records. Not all participants completed all items as the questionnaires were voluntary. Items included in this audit are summarised below.

**Statistics**

Descriptive statistics were used to summarise participant characteristics. Baseline participant characteristics between the group education and usual PLPHC care cohorts were compared using chi-square and t-tests or non-parametric equivalent. To explore responses to treatment, baseline scores were compared with follow-up scores for the APFQ and AQOL-6D and compared between groups using repeated measures ANOVA. Mean (SD) GROC scores were also calculated. Differences in patient journey...
between groups were compared using t-tests where data were normally distributed or non-parametric equivalents as appropriate. A p-value <0.05 was interpreted as significant. Satisfaction survey comments were grouped into themes and summarised. Statistical analyses were conducted using SPSS (IBM) Version 23.

RESULTS

Characteristics of participants

Between January and October 2017, 158 patients completed treatment in the PLPHC, with 105 providing consent for this audit (group education n=29, PLPHC n=76) (Figure 2). All patients referred during the audit period were able to communicate in English, alleviating any need for interpreters. At baseline, there were no significant differences between the groups regarding age, body mass index, obstetric history or gynaecological history (Table 1), nor between primary, secondary and tertiary diagnoses (Table 2).

Patient journey

Participants waited a mean of 80 days (range 0–434) on the urogynaecology waitlist prior to triage to the PLPHC. Once the referral was received by the PLPHC, participants were assessed within two to 46 days (Mean=16; SD=9) and discharged 0 to 251 days (Mean=88; SD=57) following initial assessment. Patients received a mean (SD) of 3.9 (2.1) occasions of service (range 1–9). Time from referral received in the urogynaecology clinic to first appointment for Category 3 patients potentially suitable for PLPHC reduced from a median of 372 days in the third quarter of 2016, to a median of 154 days in the same period in 2017, representing a reduction in wait time of 58.6% (Data Source: Hospital Based Corporation Information System (HBCIS), Gold Coast Hospital and Health Analytics).

There was a significantly longer ‘wait to first contact’ for the group education cohort than the usual care cohort, with a mean (SD) of 182 (86) versus 40 (34) days, respectively (p<0.001). The group education cohort also had longer duration from initial assessment to discharge than the PLPHC cohort, at 116 (66) versus 77 (50) days, respectively (p=0.01). The group education cohort required more occasions of service (5.5 versus 3.3; p<0.001), which included the education session. Fifty-three of the 105 participants were discharged without the need for review by a urogynaecologist. Physiotherapists recommended urogynaecology review for 35 participants (33%). Of these, eight participants were escalated for expedited medical review: three participants for investigation of voiding dysfunction, one participant for investigation of procidentia, another for urethral caruncle, one for vaginal cyst, one for dilated ureter, and one participant had a positive urine cytology. Two participants (2/35) independently requested urogynaecology medical review. Recommendations for further review did

Table 1: Characteristics of the participants in each group.

<table>
<thead>
<tr>
<th>Category</th>
<th>Whole cohort</th>
<th>Group education</th>
<th>PLPHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole group cohort</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age#</td>
<td>59.8 (14.5)</td>
<td>62.3 (14.5)</td>
<td>58.7 (14.5)</td>
</tr>
<tr>
<td>BMI#</td>
<td>27.0 (6.7)</td>
<td>26.4 (5.6)</td>
<td>27.2 (7.0)</td>
</tr>
<tr>
<td>Total number of diagnoses*</td>
<td>2 (2)</td>
<td>2 (2)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Parity*</td>
<td>2 (1)</td>
<td>2 (1)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>Number of vaginal deliveries*</td>
<td>2 (1)</td>
<td>2 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Number of caesarean sections*</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Previous incontinence surgery</td>
<td>4 (4%)</td>
<td>1 (3%)</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>Previous prolapse surgery</td>
<td>12 (11%)</td>
<td>4 (14%)</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Previous hysterectomy</td>
<td>21 (20%)</td>
<td>7 (24%)</td>
<td>14 (18%)</td>
</tr>
<tr>
<td>Pessary inserted</td>
<td>27 (26%)</td>
<td>7 (24%)</td>
<td>20 (26%)</td>
</tr>
<tr>
<td>Menopausal status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-menopausal</td>
<td>20 (19%)</td>
<td>5 (17%)</td>
<td>15 (20%)</td>
</tr>
<tr>
<td>Peri-menopausal</td>
<td>13 (12%)</td>
<td>4 (14%)</td>
<td>9 (12%)</td>
</tr>
<tr>
<td>Post-menopausal</td>
<td>72 (68%)</td>
<td>20 (69%)</td>
<td>52 (68%)</td>
</tr>
</tbody>
</table>

Legend: BMI=body mass index. Note: Data are #mean (SD); *median (interquartile range); or n (% of group). There were no statistically significant differences between groups (p>0.24).

Table 2: Diagnoses at initial assessment at the PLPHC

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Whole cohort n=105</th>
<th>Group education n=29</th>
<th>PLPHC n=76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary diagnosis</td>
<td>n%</td>
<td>n%</td>
<td>n%</td>
</tr>
<tr>
<td>SUI</td>
<td>21 (20%)</td>
<td>8 (27%)</td>
<td>13 (17%)</td>
</tr>
<tr>
<td>OAB</td>
<td>23 (22%)</td>
<td>7 (24%)</td>
<td>16 (21%)</td>
</tr>
<tr>
<td>POP</td>
<td>53 (50%)</td>
<td>11 (38%)</td>
<td>42 (55%)</td>
</tr>
<tr>
<td>Other</td>
<td>8 (7%)</td>
<td>3 (10%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Secondary diagnosis</td>
<td>n%</td>
<td>n%</td>
<td>n%</td>
</tr>
<tr>
<td>SUI</td>
<td>30 (28%)</td>
<td>12 (41%)</td>
<td>18 (24%)</td>
</tr>
<tr>
<td>OAB</td>
<td>7 (7%)</td>
<td>4 (14%)</td>
<td>9 (12%)</td>
</tr>
<tr>
<td>POP</td>
<td>10 (9%)</td>
<td>2 (7%)</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Other</td>
<td>20 (19%)</td>
<td>1 (7%)</td>
<td>19 (25%)</td>
</tr>
<tr>
<td>Nil</td>
<td>35 (33%)</td>
<td>9 (31%)</td>
<td>26 (34%)</td>
</tr>
<tr>
<td>Tertiary diagnosis</td>
<td>n%</td>
<td>n%</td>
<td>n%</td>
</tr>
<tr>
<td>SUI</td>
<td>3 (3%)</td>
<td>0 (0%)</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>OAB</td>
<td>7 (7%)</td>
<td>2 (6%)</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>POP</td>
<td>10 (9%)</td>
<td>2 (7%)</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Other</td>
<td>15 (14%)</td>
<td>1 (3%)</td>
<td>14 (18%)</td>
</tr>
<tr>
<td>Nil</td>
<td>70 (66%)</td>
<td>24 (83%)</td>
<td>46 (60%)</td>
</tr>
</tbody>
</table>

Legend: SUI=stress urinary incontinence, OAB=overactive bladder, POP=pelvic organ prolapse. There were no statistical differences between groups (p>0.30).
not differ between cohorts (p=0.14). Treatment was discontinued for nine participants due to failure to attend, and six were discharged at their request. This did not differ between cohorts (p>0.50).

During their management within the PLPHC, 24 participants were referred back to their GP, predominantly for prescription of topical vaginal oestrogen, and two were referred to a continence nurse advisor. Three participants were referred for pelvic ultrasound, 16 for urodynamic studies, and eight for urine microscopy, cultures and sensitivities (many participants having already completed this with their referring GP). Nineteen participants were discharged to the nurse-led pessary clinic for ongoing pessary management. Physiotherapists liaised with a urogynaecology consultant about 15 participants, regarding prescription of topical vaginal oestrogen and management of complex cases such as voiding dysfunction, procidentia and vulvar dermatological conditions. No adverse events were reported for any participant in the audit.

**Patient satisfaction**

Patient satisfaction surveys were completed by 70 participants: 18 from the group education cohort and 52 from the PLPHC cohort (Table 3). Satisfaction for overall service of the PLPHC for those in the group education session was 92mm (SD 11mm), and 95mm (SD 10mm) for the PLPHC cohort (p=0.45). There were no differences between cohorts for any of the individual aspects of satisfaction in the questionnaire (p≥0.21). There were high levels of satisfaction (89%) with the group education sessions.

Open-comment responses in the patient satisfaction surveys were grouped into three main themes:

- **Outcome** — All participants were positive about their response to treatment except for one neutral comment. Overall, participants reported being pleased with their outcome. Specific comments indicated participants were positive about avoiding surgery, and other participants reported that they felt better educated, reassured and confident. The neutral comment was: “[treatment had not] made any difference to my bladder prolapse. I feel that surgery is inevitable.”

- **Service** — Participant comments were positive about the quality of the service. Participants praised the informative and helpful nature of the service, and reported support of continuation of the clinic. Comments related to timeliness for access to appointments and punctuality of appointment times were mixed.

- **Staff** — Feedback was overwhelmingly positive about the clinic’s staff, who were described by participants as “helpful”, “professional”, and “friendly”. Generally, it was reported that staff ensured participants felt comfortable despite potentially “embarrassing” subject matter.

**Clinical outcomes**

There were 73 APFQ results available for analysis (Table 4), and overall dysfunction scores revealed the whole cohort had a significant improvement in scores at discharge (mean score baseline=31, discharge=20, p≤0.001). There were significant improvements in the bladder, bowel and prolapse domains of the APFQ for the overall cohort (p≤0.001). With respect to sexual dysfunction, there was no significant improvement at discharge, even when isolating data to the 32 women who scored greater than zero at baseline (p≥0.08). There were no significant differences in pelvic floor dysfunction outcomes between the cohorts in any of the four dimensions for bladder, bowel, prolapse, and sexual dysfunction dimensions (p≥0.09).

The AQOL-6D was correctly completed at baseline and discharge by 31 women (Table 5). The mean utility score improved significantly in the whole cohort from 0.80 (SD 0.21) to 0.85 (SD 0.19) with a mean (95% CI) change of 0.05 (0.01 to 0.09) (p=0.02). Improvements in the individual dimensions of quality of life (QoL)
were not significant except for relationships (p=0.03); however, the independent living dimension approached significance (p=0.054). There were no differences between cohorts in utility score change in AQOL-6D (p=0.30). At the time of discharge, 75 participants provided a GROC. One woman reported deterioration at –3; six women reported no change; and the remaining women reported improvements, with 15 women rating improvement at 1–2 points and 53 women rating it at 3–5 points. There were no differences between cohorts in the GROC (p=0.17).

HEALTH PROFESSIONAL SATISFACTION

Seven health professionals directly involved in the PLPHC completed a satisfaction survey. This included two consultant urogynaecologists, one urogynaecology fellow, one urogynaecology nurse, one gynaecology nurse, and two physiotherapists. All respondents reported being satisfied or very satisfied for survey domains, which included overall service, physiotherapists’ diagnostic ability and level of care, communication between team members, and overall care provided to participants. Only one respondent preferred the traditional medical model.

DISCUSSION

The inception of the PLPHC was associated with a decreased time on the waiting list for participants treated through the PLPHC. The triage process using PLPHC eligibility criteria worked well in selecting appropriate patients as evidenced by 65% patients not requiring specialist medical consultation. The low number of treatment appointments required, and positive clinical and patient journey outcomes, clearly demonstrates that primary contact physiotherapists can provide treatments of value and good clinical effect for eligible Category 3 urogynaecology waitlist patients.

The main clinical diagnoses seen in the PLPHC were POP, SUI and overactive bladder (OAB) and these conditions are known to be responsive to physiotherapy.
treatment. As a result, 53 of the 105 participants who completed treatment at the PLPHC were discharged directly from the physiotherapy service, demonstrating that these patients do not necessarily require medical consultation prior to physiotherapy intervention to achieve successful outcomes.

The audit showed that ongoing management of patients is likely to be more efficient in the PLPHC model of care due to prior completion of conservative management and appropriate investigations, making decisions regarding surgical management more straightforward and timely. The early identification of participants requiring expedited medical review was another benefit of the PLPHC model of care. That there were no clinical adverse events and 98% agreement between physiotherapist and patient regarding need for specialist review in this cohort is comparable to a previous study with 100% agreeance. This further supports the appropriateness of this model of clinic, and the appropriateness of advanced level physiotherapists to effectively manage eligible Category 3 long-wait patients.

We found no clear clinical benefit of group education at initial patient contact, other than to allow more timely access to care for the backlog of patients on the urogynaecology waitlist. Statistically significant differences between cohorts pertained to total wait time to initial assessment, number of days from initial assessment to discharge, and total occasions of service, all of which were higher for women in the group education cohort. The longer total wait time to initial assessment can be explained by the fact that women who participated in group education were those seen at the inception of the PLPHC and had already been on the waitlist before the PLPHC commenced. More occasions of service may have also been required in the group education cohort due to their lengthier wait time to access care, which may have resulted in worsening of symptoms in that time. The group education session did not replace subsequent individualised management, so this was counted as an additional occasion of service. Importantly, clinical outcomes were not different between women in the two cohorts.

There was a significant improvement across the scores of the APFQ and AQOL-6D for women in the PLPHC, regardless of how they were initially managed. This suggests both methods of service delivery are effective in the management of patients with SUI, OAB or POP. Previous studies have shown that quality-of-life domains, such as social limitation/isolation and personal relationships, show greater improvement following group education sessions. This was attributed to women experiencing relief at the realisation others shared their problem or diagnosis. Anecdotally, the women participating in the group education session reported similar benefits, and seemed better prepared for their subsequent individual assessments. For example, the women with OAB who came to the group education session consequently attended their follow-up individual assessment with an already-completed bladder diary. High levels of satisfaction with the group education session and a lack of critique in the satisfaction survey comments may indicate that this method could be considered when establishing similar health services.

Very high patient satisfaction regarding physiotherapist clinical expertise and care was reflected in the acceptance of seeing a physiotherapist rather than a doctor at initial assessment. No difference in satisfaction levels between cohorts was expected as all participants were provided with the same level of care. A 100% recommendation to family and friends captured participants’ positive experience of the PLPHC. Over 97% participants were satisfied with their waiting time to care, which was notably high as it included the increased wait time for those on the waitlist prior to clinic establishment.

High levels of professional satisfaction in communication, interdisciplinary relationships and patient flow were reported from health professionals directly involved in the PLPHC. A strength of the PLPHC was the co-location of physiotherapy services within the urogynaecology specialist outpatient department, which facilitated interprofessional communication and enabled both the patient and clinician more efficient and timely access to the multidisciplinary team. It may have also contributed to the number of ‘referrals to urogynaecology nurses’ and ‘discussion with consultant during initial consultation’ statistics, as it allowed the clinical lead physiotherapist ease of access to these professionals, and to our knowledge is not available to other similar clinics in Queensland. The number of participants referred to urogynaecology nurses is indicative of the PLPHC service accessing a nurse-led pessary clinic for ongoing monitoring and management of participants fitted with a pessary.

If clinically required, patients were also referred to urogynaecology nurses for nurse-led urodynamical studies prior to specialist consultation. Change in prescribing rights for advanced clinicians, such as physiotherapists or urogynaecology nurse practitioners, in the future may also reduce the high number of participants needing to be referred to their GP for initial prescription of topical vaginal oestrogen.

Limitations of the audit included smaller numbers in the group education cohort due to inability to obtain consent retrospectively. It may have been beneficial to have had staff assist participants with completing the questionnaires to improve on frequency of missing data. It is important to note that only those patients with apparently uncomplicated conditions amenable to physiotherapy treatment were referred to the PLPHC, and the physiotherapists working in the clinic had a
high level of clinical skill, knowledge and experience in women’s health physiotherapy.

Preliminary research has indicated up to a 40–50% reduction in cost per occasion of service through implementation of a PLPHC model rather than a traditional medical model[11]. Although this study did not include cost analysis, it could be presumed that providing efficient and timely clinical care, more efficient use of specialist appointments and reduced medical interventions would be a more effective use of resources. Furthermore, there may be financial benefit to running an initial group education session to reduce wait times. Future research to assess the economic benefit and cost-effectiveness of this model of clinic would be beneficial.

CONCLUSION

A pelvic health clinic led by advanced practice physiotherapists is an effective model of care for management of SUI, OAB and POP, regardless of group or individual initial contact. It is successful in providing good clinical outcomes, demonstrates high patient and staff satisfaction, is an efficient means of reducing long urogynaecology specialist outpatient waitlists, and streamlines urogynaecology patient flow. The PLPHC model should be considered as a viable economical model of care for appropriately triaged, non-urgent patients diagnosed with urogynaecological conditions.

REFERENCES


