

ORIGINAL ARTICLE

Evaluation of a pelvic health physiotherapy service in remote Australia

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ABSTRACT

Pelvic health physiotherapy care is considered best practice for managing many pelvic health conditions. However, access to pelvic health physiotherapy varies greatly, and may be lacking in rural and remote areas of Australia. This study reports an evaluation of a new pelvic health physiotherapy service model in the Kimberley region of Western Australia, undertaken from July–December 2021. The objective of this evaluation was to document patient and service outcomes, consumer satisfaction and key stakeholder feedback, to guide ongoing need and development of such a service. A total of 113 referrals were managed by the new service, resulting in over 199 appointments and involving 77 patients. Many of the 60 patients who attended their booked appointments had significant symptoms and most (76.7%) had experienced symptoms for more than one year. Consumer feedback was positive, and all key stakeholders reported it was either moderately, very, or extremely important that the new service continue. This evaluation demonstrated a clear need and support for pelvic health physiotherapy services in the region, and documented a successful model of care, working alongside the existing generalist physiotherapy model. Future priorities are to implement culturally-informed models of pelvic health care to improve access for Aboriginal and Torres Strait Islander people with pelvic health conditions, and to examine other service models that improve access to pelvic health physiotherapy in under-served regions.

Keywords pelvic floor dysfunction, pelvic health physiotherapy, models of healthcare, rural and remote Australia.

INTRODUCTION

Pelvic health conditions are a significant health problem globally. Approximately 25–45% of women and 5–32% of men experience urinary incontinence (UI), 10–20% of adults experience overactive bladder (OAB) (urinary urgency, frequency and nocturia) and 5–10% of women experience pelvic organ prolapse (POP).¹ Additionally, 25% of women² and 8% of men³ experience persistent pelvic pain. UI is known to impact negatively on one's ability to participate in household, work, physical, social and sexual activities; as well as sleep; energy and emotional status.⁴ POP can cause bladder, bowel and sexual dysfunction, and impact negatively on quality of life and psychosocial well-being.⁵ Urinary and faecal incontinence are major risk factors for admission to an aged care facility.⁶ Thus, pelvic health conditions can have substantial physical, functional, social and emotional impacts across the lifespan.

In a recent Australian study on pelvic floor health in community dwelling people aged 40–75 years, 65% reported at least one bladder symptom and 35% reported stress urinary incontinence.⁷ Existing evidence suggests the burden of pelvic health conditions is higher in rural and remote areas and under-addressed.^{8,9} In the Kimberley region of Western Australia, of which Aboriginal and/or Torres Strait Islander people are approximately 40% of the whole population,¹⁰ a study among older Aboriginal people found 36% of those aged 45 years and older, and 50% of those over 80 years old reported urinary incontinence.⁸ A 12-month audit in the Northern Territory suggests female UI is underreported, accounting for only 3% of gynaecology consults, and likely undermanaged. For example, only 19% of those with UI appropriate for a trial of conservative management were formally referred to pelvic health physiotherapy.⁹

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Pelvic health physiotherapy refers to the assessment and management provided by a physiotherapist with additional training in managing pelvic health conditions. Pelvic health physiotherapy, including supervised pelvic floor muscle training and bladder training, is considered best practice and first line management of many pelvic health conditions including UI, OAB and POP.¹¹ Pelvic health physiotherapists are also recommended in the multi-disciplinary management of persistent pelvic pain,¹² and in the care following an obstetric anal sphincter injury (OASI).¹³

Accordingly, the role of physiotherapy in the management of pelvic health conditions is expanding. Around Australia, some health services have successfully established advanced scope physiotherapy clinics,¹⁴⁻¹⁶ whereby appropriate urology or gynaecology referrals are redirected to a physiotherapist with advanced training for initial assessment and a period of conservative management. These models are based on extended scope allied health service models and represent a cost-effective and consumer accepted alternative to the usual medical model of care.¹⁷ However, these models have been established in metropolitan centres or large regional facilities; little is known about the adaptation of such models in rural and remote areas of Australia, such as the Kimberley.

Access to any physiotherapy in remote Australia is limited; there is less than half the employed physiotherapy full time equivalent (FTE) staff per 100,000 in *very remote areas* (45.5) compared to the *major cities* (101.5).¹⁸ Access to pelvic health physiotherapy is likely to be even lower because of the limited availability of physiotherapists with additional pelvic health training. Further, those living remotely have higher rates of health risk factors and a higher burden of disease, and healthcare is usually provided over a greater geographical area.¹⁸

In Western Australia (WA), the WA Country Health Service (WACHS) provides freely available, public health services, including allied health services, to regional, rural and remote WA. Allied health services, including physiotherapy, are often generalist (meaning they have a broad scope of practice as opposed to single specialty area), based at a regional centre and travel to outlying towns and communities. Within the WACHS regions, people requiring public physiotherapy care for pelvic health issues are usually seen by physiotherapists working in generalist positions, who may not necessarily have additional training in pelvic health care. Many people in country WA may therefore be unable, or have limited access to, best practice conservative management for pelvic health conditions.

To maximise evidence-based care for pelvic health conditions in a rural and remote setting, the WACHS Kimberley physiotherapy departments have initiated an alternative pelvic health physiotherapy service model. This article outlines a model of pelvic health physiotherapy in a remote region of WA, describing patient and service outcomes, consumer satisfaction and stakeholder feedback in order to guide future delivery of similar services.

METHODOLOGY

Setting

The Kimberley is the northern most region of WA, encompassing an area of 424,517 square kilometres⁹ and has a population of approximately 34,000, with 41.1% identifying as Aboriginal and/or Torres Strait Islander.¹⁰ According to the Australian Statistical Geographical Standard Remoteness Areas (2016), the entire region is classified as Remote or Very Remote²⁰ (see Figure 1).

Public physiotherapy services are situated in the largest three Kimberley towns, Broome, Derby and Kununurra, with outreach services provided to smaller towns and communities within their respective local government areas. The WACHS Kimberley pelvic health physiotherapy service initiative, provided a regional dedicated service for the assessment and management of pelvic health conditions.

A part time (0.6 FTE) clinician (Dwyer), with post-graduate qualifications in pelvic health physiotherapy, was based in Kununurra and provided regular clinical services to Broome, Derby, Fitzroy Crossing and Halls Creek. To minimise travel time, a monthly five-day circuit, by light plane, was utilised to travel to the four other major sites across the region (approximately two hours of travel time to each location). To reduce costs, travel was undertaken on flights that were already being chartered by the regional health service, when possible. Face-to-face clinical consults were offered in Kununurra and during the monthly trips to other sites, and appointments via phone and telehealth services were offered between face-to-face consults, as required. Visits from Kununurra to smaller sites and communities, occurred when there was enough demand.

This quality improvement project evaluated the new pelvic health physiotherapy service model using quantitative and qualitative methods, from July–December 2021. Data was captured from commencement of the service using a range of routinely collected information, including service and patient-related information. Key stakeholders were invited to provide feedback after approximately five-months duration of the new service model.

Ethical considerations

This project did not differ from routine clinical care or health service quality improvement. Approval was received from the Low & Negligible Risk Subcommittee of the WACHS Human Research Ethics Committee (LNRP 2021.09).

Service-related information

Service-related information was collected for accepted referrals to, and related appointments for, the new pelvic health physiotherapy service over the service evaluation period. Service-related information was collected using the clinical application Web Patient Administration System (Webpas)²¹ used in the region

and included: referral numbers and waiting times to pelvic health physiotherapy service; appointment attendance and service mode; appointment attendee demographics (service site, gender, age, ethnicity) and appointment discharges with occasions of service.

Patient-related information

All patients were given the Participant Information and Consent Form (PICF) at their first presentation, or as soon as practically possible. The PICF provided

an overview of the Quality Improvement (QI) Project, was supported by a verbal explanation and patients were given the opportunity to ask questions. Patients were able to provide consent for their de-identified patient-related data to be used for the purpose of the QI project.

Female patients who attended an initial pelvic health physiotherapy appointment during the new service initiative were asked to complete the Australian Pelvic

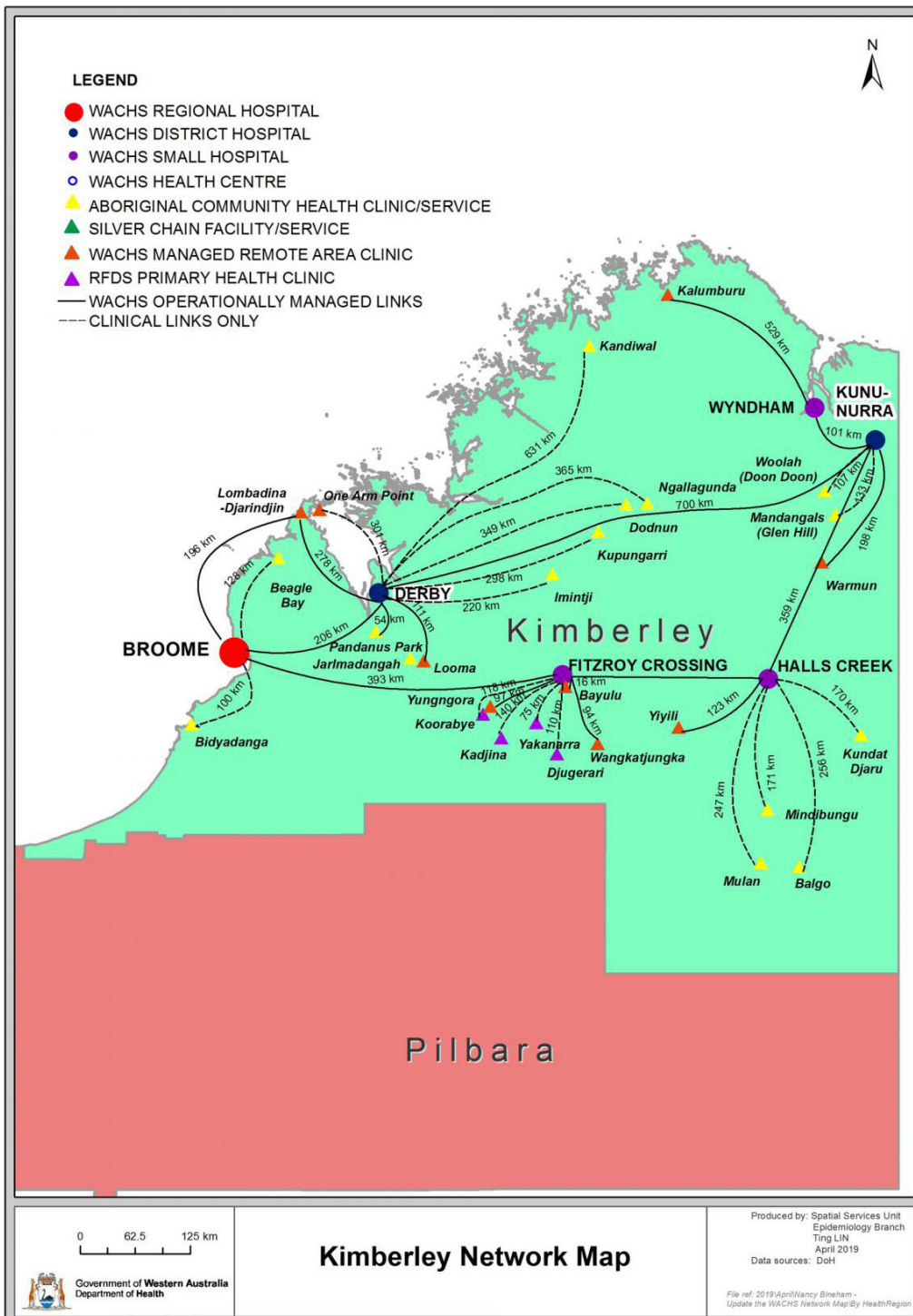


Figure 1. Kimberley Network Map (Page 5)
 Accessed: WA Country Health Service – Kimberley, 06/06/2023

Floor Questionnaire (APFQ).²² The self-administered APFQ has been validated²³ and is widely used in routine clinical practice. The questionnaire includes 42 questions relating to four domains: bladder (15 questions), bowel (12 questions), sexual function (10 questions) and prolapse symptoms (5 questions), covering symptom severity, impact on quality of life and symptom bothersomeness. Each domain score is divided by the number of questions in that domain and multiplied by 10 to give a value between 0 and 10 for each domain, and a total score out of 40 (or 30 if not sexually active). Higher scores indicate higher symptom severity.

All patients were invited to complete the Kimberley Population Health Unit (KPHU) Customer Satisfaction Survey (CSS) (Appendix 1) on at least one occasion during their clinical journey. The KPHU CSS includes six 5-point Likert scale questions, five yes/no questions, one multiple choice question and one free text question. This survey is readily available in most KPHU clinical areas.

Broad symptom profile information was also collected by the treating physiotherapist including primary diagnosis (bladder/bowel/prolapse/pain/sexual dysfunction) and duration of symptoms.

Stakeholder feedback

Key stakeholders included obstetric and gynaecological consultants, general practitioner obstetricians, general practitioners, generalist physiotherapists, clinical midwives (hospital and community based), practice nurses and Aboriginal Allied Health clinical support staff. Feedback was sought from at least one key stakeholder at each of the included Kimberley sites.

Stakeholder consultation was sought via an anonymous online survey administered using Qualtrics (Qualtrics, Provo, UT),²⁴ after approximately five months of the new service initiative. The survey included brief introductory information, asked the respondent's profession and six questions relating to the new service model (eg benefits and potential improvements of the new service, see Appendix 2).

Data Management and Analysis

Quantitative data were entered into SPSS version 24 (Armonk, NY: IBM).²⁵ Descriptive statistics were used to summarise service-related data and patient demographic information. The APFQ was summarised using mean and standard deviation (SD) for each domain and total score. Quantitative data of the CSS and key stakeholder feedback was summarised using the mean, SD and median of Likert scale items, percentage answered yes to yes/no questions, and frequencies for the multiple-choice question and profession. Qualitative data from the CSS and key stakeholder surveys underwent thematic analysis by organising data into common theme areas. This was initially undertaken by one author (Dwyer). A summary of themes was then discussed between authors, and a back-and-forward process between summary and the data, as a way to examine and challenge findings

was utilised, and resulted in agreed upon thematic categories.

RESULTS

Service-related information

Referrals for pelvic health conditions continued to be directed to physiotherapy departments within each town and forwarded to the pelvic health physiotherapy service, based on collaboration with generalist physiotherapists and agreed referral criteria, depending on the local physiotherapy skillset. For two of the regional departments (Derby and Kununurra) referral criteria included referrals for management of any symptoms of pelvic floor muscle dysfunction. The third department (Broome) chose to continue to manage this caseload locally and refer clients with complex pelvic health conditions to the new service (for example, multiple pelvic health conditions or refractory persistent pelvic pain). At the commencement of the project, there were 71 existing referrals (waiting and active) being managed by the treating physiotherapist and continued into the dedicated service, as they either met referral criteria (Derby & Kununurra) or for patient continuity of care (Broome). During the service evaluation period 42 new referrals to the dedicated service were received (Table 1). Referral waiting times until first appointment ranged from 0–476 days (Table 2), noting that there were 36 waiting referrals at the commencement of the service evaluation period.

A total of 199 appointments were booked during the service evaluation period; 21 in Broome (10.6%), 67 in Derby and Fitzroy Crossing (33.7%), and 111 in Kununurra and Halls Creek (55.8%). The mode of service delivery for booked appointments was in person (175, 87.9%), telephone (22, 11.1%) or home visit (2, 1%). Most appointments were attended (120, 60.3%), 51 (25.6%) were not attended and 28 (14.1%) were either cancelled or rescheduled. Of the 120 attended appointments, 15 resulted in the referral being closed due to treatment completion. Treatment was deemed complete after 1–10 appointments (average 3.6) for those referrals closed during the service evaluation period. Of the 51 non-attended appointments, six resulted in the referral being closed due to local discharge policy (three non-attended appointments and an inability to contact the patient via two different methods). In addition, 16 referrals were closed without an appointment as services were declined, or the patient had moved away from the Kimberley; this was called an 'admin discharge', (see Table 2).

Patient related information

Basic demographic information of the 77 individual patients that had booked appointments during the service evaluation period is captured in Table 3. Most patients were female, age ranged from 15–95 years and 39% identified as Aboriginal and/or Torres Strait Islander. Aboriginal and/or Torres Strait Islander patients accounted for 34% of the 120 attended appointments and 65% of the 51 non-attended appointments. Of the 60 patients who attended appointments, bladder

Table 1. Referral numbers prior, during and after dedicated pelvic health physiotherapy service evaluation period

| Site | Number of existing referrals at start of evaluation period | Number of referrals received during evaluation period | Number of referrals closed during evaluation period | Number of existing referrals at end of evaluation period |
|----------------------------|--|---|--|--|
| Broome | 11: 10 active (91%) 1 waiting (9%) | 1 (total 12) | 7: 2 treatment complete 4 admin discharge 1 discharge policy | 5 (decreased 54.5%): 5 active (100%) |
| Derby and Fitzroy Crossing | 26: 13 active (50%) 13 waiting (50%) | 17 (total 43) | 11: 4 treatment complete 5 admin discharge 2 discharge policy | 32 (increased 23.1%): 20 active (62.5%) 12 waiting (37.5%) |
| Kununurra and Halls Creek | 34: 12 active (35%) 22 waiting (65%) | 24 (total 58) | 19: 9 treatment complete 7 admin discharge 3 discharge policy | 39 (increased 14.7%): 26 active (66.7%) 13 waiting (33.3%) |
| Total | 71: 35 active (49%) 36 waiting (51%) | 42 (total 113) | 37: 15 treatment complete 16 admin discharge 6 discharge policy | 76 (increased 7.0%): 51 active (67.1%) 25 waiting (32.9%) |

Active = patient had already had at least one booked appointment; waiting = waiting for first appointment; referral closed = no longer requiring service for one of three reasons: treatment complete (symptoms resolved or referred for further management elsewhere), admin discharge or discharge policy.

Table 2. Referral wait times (days) for waiting referrals at start, to booked first appointment during and waiting referrals at end of service evaluation period

| Site | Referral wait times at start of evaluation period | | | Wait times to booked first appointment, during evaluation period | | | Referral wait times at end of evaluation period | | |
|----------------------------|---|-------|--------|--|------|-------|---|------|--------|
| | Number of referrals | Mean | Range | Number of referrals | Mean | Range | Number of referrals | Mean | Range |
| Broome | 1 | 167 | | 2 | 138 | 7-269 | 0 | | |
| Derby and Fitzroy Crossing | 13 | 101.5 | 21-348 | 16 | 117 | 1-476 | 12 | 92 | 15-287 |
| Kununurra and Halls Creek | 22 | 136.9 | 24-353 | 32 | 143 | 0-426 | 13 | 121 | 16-358 |
| Total | 36 | 124.9 | 21-353 | 50 | 135 | 0-476 | 25 | 107 | 15-358 |

symptoms were the most common primary complaint (29, 48.5%) and most had experienced symptoms for more than one year (46, 76.7%).

A total of 40 patients were provided with the PICF; 38 provided consent for their additional patient-related information to be included, one declined and one did not return the form following a telephone appointment. The PICF was not provided to 20 patients due to time constraints during the appointment or when deemed inappropriate (eg identified need to address patient safety, clinical escalation or reduced service engagement). The Australian Pelvic Floor Questionnaire (APFQ) and the Consumer Satisfaction Survey (CSS) were completed by 25 and 20 of the consenting patients, respectively. Both the bladder and bowel symptom subscales on the APFQ had equal mean scores of 2/10, sexual function 1.9/10 and

prolapse 1.2/10 (potential range of 0-10, with higher scores indicating higher symptom severity). Total mean scores were 6.2/40 for those completing all subscales and 10.2/30 for those not sexually active (Table 4).

The CSS demonstrated most patients scored 1/5 (happy) on the Likert Scale questions relating to hours of service, privacy, confidentiality, involvement in care, would recommend, and helpful staff, and most patients answered Yes on the questions relating to awareness of rights, involvement of carer in decisions and expectations. There were seven additional positive feedback comments and one constructive suggestion, (Table 5).

Stakeholder Feedback

Stakeholder feedback was sought from 19 stakeholders across the region; 14 commenced the survey and 11

Table 3. Patient demographics

| Demographics (n = 77) | | N (%) |
|--|--|---------|
| Gender | Female | 72 (94) |
| | Male | 5 (7) |
| Age | 15-24 | 8 (10) |
| | 25-34 | 24 (31) |
| | 35-44 | 11 (14) |
| | 45-54 | 10 (13) |
| | 55-64 | 16 (21) |
| | 65-74 | 5 (7) |
| | 75-84 | 2 (3) |
| | 85-95 | 1 (1) |
| Ethnicity | Aboriginal and/or Torres Strait Islander | 30 (39) |
| | Non Aboriginal and/or Torres Strait Islander | 47 (61) |
| Symptomology (n=60) | | N (%) |
| Primary symptom | Bladder | 29 (48) |
| | Bowel | 6 (10) |
| | Prolapse | 7 (12) |
| | Pain | 7 (12) |
| | Sexual | 4 (7) |
| | Postnatal or OASI | 6 (10) |
| | Pre/post RP | 1 (2) |
| Duration of symptoms | <6 months | 9 (15) |
| | 6-12 months | 3 (5) |
| | 13-24 months | 9 (15) |
| | 2-5 years | 15 (25) |
| | 6-10 years | 9 (15) |
| | >10 years | 11 (18) |
| | Other | 4 (7) |
| | - unsure (many years, long time) | 2 (3) |
| - resolved | 1 (2) | |
| - asymptomatic (pre radical prostatectomy) | 1 (2) | |

completed the survey and were included in the analysis. Stakeholders who completed the survey included physiotherapists, midwives, general practitioners and one non-specified profession, and all were aware of the new service model. Similar themes arose in response to the questions *What has changed* and *What are the benefits* of the new service model: improved healthcare/patient outcomes, access to a dedicated pelvic health physiotherapy service and increased professional development and education opportunities for physiotherapists and other health professionals. An additional benefit reported was the more specialised physiotherapy career pathway, in a rural setting. The

Table 4. Australian Pelvic Floor Questionnaires (APFQ)

| Symptoms Subscale | Score mean (SD) | Score range |
|--|----------------------|--------------------|
| Bladder (n=25) | 2.0 (1.7) | 0-6.9 |
| Bowel (n=25) | 2.0 (1.4) | 0-5.3 |
| Prolapse (n=25) | 1.2 (1.7) | 0-5.6 |
| Sexual Function (n=21) | 1.9 (1.8) | 0-5.7 |
| Total (including all subscales) n=21; n=25 | 6.2 (3.0); 6.8 (3.8) | 1.3-14.8; 1.3-17.2 |
| Total (without sexual function subscale) n=4 | 10.2 (5.8) | 3.0-17.2 |

Note: 3 questionnaires were completed after the commencement of pelvic health physiotherapy interventions.

areas for improvement included the referral pathway to access the pelvic health physiotherapy service and the organised and continued professional development of generalist physiotherapists. Additional comments were grouped into the themes of continuing the dedicated service model, continuing the development of generalist physiotherapists and clinician feedback, (Table 6).

DISCUSSION

Overall, the results of this project demonstrated a clear need for pelvic health physiotherapy services in the Kimberley. The new service received a substantial number of referrals, there were significant wait times to first appointment, and patients presented with long standing and complex pelvic health symptoms. The new service was supported by both patients accessing it and key stakeholders. While some longer wait times reflect being unable to contact some patients, and the average waiting time reduced over the service period, given there were 36 waiting referrals at the start of the service initiative, analysis over a longer period may assist to determine true demand and whether additional resources are required or alternative service models need to be considered.

The APFQ results suggest patients accessing the new service had symptoms at similar or just below the severity of a population presenting for their first appointment at a tertiary urogynaecological referral unit,²³ highlighting that patients were presenting with significant symptoms. The majority of patients seen during the service evaluation period (66.7%) had symptoms for longer than one year, which supports the need for a timely service, but may also suggest patients are either under reporting symptoms or referrals are delayed.⁹ Consumers demonstrated high rates of satisfaction with the new service model, and all key stakeholders reported it was moderately to extremely important that the service continue, thus the service need was also supported by consumers and stakeholders.

The Kimberley, and most of regional Australian public allied health services, utilise a generalist clinician

Table 5. Consumer Satisfaction Survey (CSS)

| Likert Questions | 1 😊 | 2 | 3 | 4 | 5 😞 | Missing | Mean (SD) | Median |
|--|--------------|---|---------|---|---------|---------|-------------|--------|
| Q1 Hours of Service suited? | 18 | 1 | 1 | 0 | 0 | 0 | 1.2 (0.5) | 1 |
| Q4 Privacy and dignity maintained? | 17 | 2 | 1 | 0 | 0 | 0 | 1.3 (0.9) | 1 |
| Q5 Info kept confidential? | 19 | 1 | 0 | 0 | 0 | 0 | 1.2 (0.9) | 1 |
| Q6 Involve you in care decisions? | 18 | 1 | 0 | 0 | 1 | 0 | 1.3 (0.9) | 1 |
| Q9 Recommend to a friend? | 17 | 0 | 0 | 0 | 1 | 2 | 1.2 (0.9) | 1 |
| Q10 Staff helpful? | 16 | 1 | 0 | 0 | 1 | 2 | 1.3 (1.0) | 1 |
| Yes / No Questions | Yes (%) | | No (%) | | NA (%) | | Missing (%) | |
| Q2 Aware of rights? | 20 (100) | | 0 | | 0 | | 0 | |
| Q3 Seen rights? | 9 (45) | | 11 (55) | | 0 | | 0 | |
| Q7 Involve carer in decisions? | 6 (30) | | 0 | | 14 (70) | | 0 | |
| Q8 Involve you in care decisions about child? | 3 (15) | | 0 | | 16 (80) | | 1 (5) | |
| Q11a) Expectations met at reception? | 15 (75) | | 0 | | 3 (15) | | 2 (10) | |
| Q11b) Expectations met with wait times? | 14 (70) | | 0 | | 3 (15) | | 3 (15) | |
| Q11c) Expectations met with Ax and care? | 16 (80) | | 0 | | 0 | | 4 (20) | |
| Q11 Additional comments | Comments (n) | | | Comments (quote) | | | | |
| Positive feedback re: service – professional, informative, holistic. | 7 | | | Very professional, explains things clearly, caring approach Friendly staff, caring and professional, you have a lovely team (from Q13) | | | | |
| Q13 Other suggestions | Comments (n) | | | Comments (quote) | | | | |
| Constructive feedback re: consumer engagement. | 1 | | | Visit clients in community and show you are interested in their health issues. They do not always come to clinic. | | | | |

Table 6. Stakeholder feedback

| | | n | % |
|---------------------------|-------------------------|------------------|-------|
| Survey completion | Surveys sent | 19 | 100% |
| | Complete surveys | 11 | 57.9% |
| | Incomplete Surveys | 3 (not included) | 15.8% |
| Profession | Physiotherapist | 5 | 45.4 |
| | Midwife | 2 | 18.2 |
| | GP | 3 | 27.3 |
| | Other (did not specify) | 1 | 9.1 |
| Aware of service? | Yes | 11 | 100% |
| Importance of continuing? | Not at all important | 0 | 0 |
| | Slightly important | 0 | 0 |
| | Moderately Important | 1 | 9.1 |
| | Very Important | 2 | 18.2 |
| | Extremely important | 8 | 72.7 |

Table 6. Stakeholder feedback continued

| What has changed? | Comments (n) | Comments (quote) |
|--|--------------|---|
| Improved healthcare / access to healthcare | 6 | “Known referral pathway for postnatal women” (midwife) “..increased services for those with pelvic health complaints” (physiotherapist) |
| Dedicated Pelvic Health PT service | 3 | “Clients can now get timely specialist pelvic health physio treatment...” (physiotherapist) “I can refer patients specifically to see Pelvic Health Clinician for women’s health physio issues.” (general practitioner) |
| Education to other health care providers. | 2 | “PD opportunities, dedicated case conferencing with pelvic health physio, regional QI initiatives commenced” (physiotherapist) |
| Generalists not seeing Pelvic Health clients | 1 | “.. and generalists no longer see pelvic health clients” (physiotherapist) |
| What are the benefits? | Comments (n) | Comments (quote) |
| Improved patient outcomes | 8 | “Improved Quality of life. ‘Closes the gap’- women can stay on country to access care” (midwife) “More women can access support for problems associated with child birth and prolapse issues.. ..actually talk to someone who understands” (other) |
| Dedicated Pelvic Health PT Service | 4 | “The community are able to access the specialist skills that are required for this clinical area” (physiotherapist) “Support, treatment & the correct advice for women’s health in the Kimberley region” (midwife) |
| Career progression in rural setting / professional development | 4 | “Shows the potential for career growth in the rural/ remote setting” (physiotherapist) “Upskilling of local therapists. Increased profile of pelvic health physiotherapy” (physiotherapist) |
| Revised regional service | 2 | “Whole of service planning. Measures to standardise aspects of service across region” (physiotherapist) |
| What could be improved? | Comments (n) | Comments (quote) |
| Continue service / nothing | 6 | “Keep service going in Kimberley and east Kimberley” (other) |
| Referral processes | 3 | “Streamline e-referral process directly to Pelvic Health Clinician - at present these referrals are through the general physio department which seems not to be passed on to this specialised women’s health physio” (general practitioner) |
| Generalist physiotherapy staff upskilling | 2 | “Organised PD sessions/joint appointments for staff upskilling” (physiotherapist) |
| Additional Comments | Comments (n) | Comments (quote) |
| Continue dedicated Service | 3 | “Women need services like this to support women’s health, make women feel more confident in dealing with issues” (other) |
| Continue generalist Physio development | 1 | “Continue to develop a strong shared-care pelvic health service and increase the profile of pelvic health physiotherapy across the region” (physiotherapist) |
| Clinician feedback | 1 | “Pelvic Health Clinician is wonderful with the women and understands the challenges in the Kimberley” (midwife) |

service model²⁶ because of the broad scope of practice and the relatively low physiotherapy workforce relative to the population size.¹⁸ However, in relation to pelvic health physiotherapy, the teaching of skills in undergraduate training programs across Australia is highly varied,²⁷ and not taught at a level which

enables graduates to practice clinically in this area.²⁸ Clinicians require additional professional development or education to do so,²⁸ however developing advanced skills in pelvic health care is challenging when physiotherapists have a generalist workload. Indeed, the large number of existing referrals at the start of

this service initiative is most likely due to a lack of generalist physiotherapists with the skills to manage pelvic health conditions. Offering a regional dedicated pelvic health physiotherapy service, alongside local generalist physiotherapy services is one way to ensure this service need is met in rural and remote areas.

This service model initiative was feasible because a physiotherapist with post graduate training in pelvic health, was located in the region (Dwyer), which may not be the case in other areas. Alternative service models, such as telehealth may be an option for regions to access physiotherapists with advanced pelvic health knowledge based elsewhere, and has been reported to be effective and a cost-effective way to manage pelvic floor conditions.^{29,30} However, a recent survey on telehealth and the provision of pelvic health physiotherapy, highlighted several challenges with this model, including the safety and effectiveness of assessments via telehealth and access to reliable internet in rural and remote areas.³¹ Further, in the context of the Kimberley, we posit that face-to-face care is optimal to manage many pelvic health conditions. Telehealth models were utilised in the region by necessity during Covid-19 restrictions for the six months immediately following the service evaluation period; reduced attendance rates were noted and a number of patients declined telehealth services citing a preference to wait for in-person appointments. An appreciation of the local context, and ease of liaising with other care providers are additional benefits of a local, face-to-face service, when possible.

A higher proportion of non-attendance for patients identifying as Aboriginal and/or Torres Strait Islander was noted, suggesting the accessibility and cultural appropriateness of this service warrants further investigation to reduce access barriers for Aboriginal and Torres Strait Islander people. At all sites the service ran out of the local hospital, whereas one consumer feedback comment suggested visiting patients in the community. While privacy in the community setting has been identified as a possible barrier to providing pelvic health physiotherapy services, partnering with local Aboriginal Community Controlled Health Care Services can improve access to rehabilitative healthcare.³² Given the high disease burden of pelvic floor conditions for Aboriginal women and recommendations for increased education and access to pelvic floor physiotherapy,³³ this is a future priority.

In this quality improvement project, a possible limitation was that the project lead (Dwyer) was also the physiotherapist trialing the new service model, thus there is the potential for bias. Attempts were made to mitigate this by including service-related information, self-reported patient related information (APFQ), anonymous consumer feedback (KPHU CSS), and online anonymous data collection for stakeholder feedback. As the CSS was completed by only 25 of the 60 patients seen (42%) and the stakeholder feedback was completed by 11 of the 19 people it was sent to (58%), all perspectives may not have been captured.

CONCLUSION

A dedicated pelvic health physiotherapy service model was successfully initiated in the Kimberley, meeting an unmet need and receiving positive consumer and stakeholder feedback. Providing best practice care in a remote setting is not without challenges; future consideration should include examining other service models to maximise access to pelvic health physiotherapy in underserved areas, and exploring the cultural appropriateness of pelvic health care.

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CONFLICTS OF INTEREST

The authors declare no conflict of interest.

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Appendix 1. Kimberley Population Health Unit Customer Satisfaction Survey





Government of Western Australia
WA Country Health Service

Customer Satisfaction Survey  2. Partnering with Consumers

The staff of the Kimberley Population Health Unit strive to give the best possible service to our clients. We need to know what you think that we are doing well to help maintain a high standard of service. When things do not go as well as they should, we also need to know so that we can make improvements. We would greatly appreciate your help by telling us about your recent visit to the clinic. Please take some time to complete the survey, should you require some assistance we will provide someone to help, or you can ask a relative or friend.

1. Do you find our hours of service meet your needs?

 1 2 3 4 5 

2. Did you know that as a client of community based services you have rights and responsibilities?

Yes No

3. Have you seen a copy of these rights and responsibilities?



Yes No

(Rights and Responsibility Brochures are available at reception in your clinic)



4. Do you feel your privacy and dignity are maintained by staff?

 1 2 3 4 5 

5. Do you feel the information you provided to us is kept confidential?

 1 2 3 4 5 

6. Do staff involve you in decisions made about your care?

 1 2 3 4 5 

7. Do staff involve your carer in decisions made about your care?

Yes No Not Applicable

8. Do staff involve you in decisions about the care of your child?


Yes No Not Applicable

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Customer Satisfaction Survey

continued

9. If a friend needed health care, would you recommend our service?


1
2
3
4
5


10. In general how helpful was the staff?


1
2
3
4
5


11. When you visited any of our clinics, did the following meet with your expectations?

a) Response at Reception Y N N/A

b) Waiting times Y N N/A

c) Assessment and care provided by:

Aboriginal Health Worker (AHW) Y N N/A

Nurse Y N N/A

Doctor Y N N/A

Allied Health Worker Y N N/A

Comments.....

12. What health promotion education sessions do you think would be useful to your community?

- Tick all that apply:
- | | | |
|--|--|---|
| <input type="checkbox"/> Health eating | <input type="checkbox"/> Healthy living | <input type="checkbox"/> Sexual health |
| <input type="checkbox"/> Child health | <input type="checkbox"/> Mums and Bubs | <input type="checkbox"/> Women's health |
| <input type="checkbox"/> Men's health | <input type="checkbox"/> Alcohol and drugs | <input type="checkbox"/> Quit smoking |
| <input type="checkbox"/> Mental health | | |

13. Any other suggestions for ways to make things better in our service delivery?

Comments

Your time and effort to complete this survey will allow us to evaluate the standards of client care and implement any changes required to improve our service. Please complete and return this form to the suggestion box in the clinic. Thank you for your participation.

Appendix 2 Key Stakeholder Feedback Survey

Brief introductory information

Thank you for taking the time to complete this short survey.

As you are hopefully aware, the Kimberley physiotherapy departments are currently trialing a slightly different approach to the management of the pelvic health physiotherapy caseload. Previously this caseload was managed by each department, with varying levels of skills/experience. At present we are trialing the provision of these services by a dedicated pelvic health physiotherapist, with relevant post-graduate qualifications, at most sites in the Kimberley.

As part of the evaluation of this service trial we are seeking feedback from relevant health professionals via this short, anonymous online survey. Questions have been kept simple and to one page, however we encourage your detailed responses. The more information you can provide, the more we can understand this service, its value and how it can be improved. The collective information provided in this survey may be disseminated (eg presented/published).

Please note that as this survey is anonymous, once answers are submitted, they will not be able to be withdrawn. If you have any questions or concerns regarding this survey, please do not hesitate to contact Pelvic Health Physiotherapy Project Lead, Stephanie Dwyer on stephanie.dwyer@health.wa.gov.au

Survey

What is your profession? (Generalist medical practitioner / specialist medical practitioner / nursing professional / midwifery professional / physiotherapist / other)

The following questions relate to the new Kimberley Pelvic Health Physiotherapy service

Were you aware of this new service trial? (yes/no)

What has changed as a result of the new Pelvic Health Physiotherapy service? (Free text)

What are the benefits? (Free text)

What could be improved? (Free text)

Please rate how important you think it is that this service is continued? (Not at all / slightly / moderately / very / extremely)

Do you have any additional comments or feedback? (Free text)

CONCLUSION

Thank you for completing this survey, your time and responses are very much appreciated. If you have any questions relating to this survey or the Kimberley Pelvic Health Physiotherapy service trial, please contact Stephanie Dwyer on stephanie.dwyer@health.wa.gov.au.