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Better together: multidisciplinary approach improves adherence to pelvic floor physical therapy

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Abstract

Introduction and hypothesis—To determine whether consultation with pelvic floor physical therapy (PFPT) at the time of initial urogynecologic evaluation increases adherence to PFPT and to identify factors associated with PFPT attendance and completion.

Methods—We performed a retrospective chart review of all patients evaluated for new urogynecology consultation at our institution in a 1-year period, abstracting data about demographics, diagnoses, and PFPT referral, attendance, and completion. Descriptive analyses compared patients who were referred to, attended, and completed PFPT, stratified by whether they saw PFPT the same day as their initial urogynecologic consultation. Logistic regression identified factors associated with PFPT attendance, completion, and referral.

Results—PFPT referral was made for 35% (335/958), of whom 67% attended and 42% completed PFPT. Patients who saw PFPT the same day as their first urogynecology visit were significantly more likely to attend PFPT than those who did not (91% vs. 61%, $p < 0.001$), but completion rates did not differ (49% vs. 41%, $p = 0.15$). PFPT attendance was higher among women who saw a PFPT the same day as their initial urogynecology appointment ($p < 0.001$) and among those aged ≥ 65 years ($p = 0.015$). Age ≥ 65 years and white, non-Hispanic race/ethnicity were associated with PFPT completion. Patients with a diagnosis of pelvic organ prolapse or urinary incontinence and those seen in multidisciplinary clinic were more likely to be referred to PFPT.

Conclusions—PFPT consultation at the time of initial urogynecologic evaluation improves attendance of initial PFPT appointment, but does not improve completion rates.

Keywords

Pelvic organ prolapse; Urinary incontinence; Pelvic floor disorders; Physical therapy modalities

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Introduction

Pelvic floor muscle exercises are a mainstay in the treatment of pelvic floor disorders such as urinary incontinence, overactive bladder, pelvic organ prolapse, and fecal incontinence. Women are more likely to report improvement in incontinence symptoms when they participate in directly supervised pelvic floor physical therapy (PFPT) as opposed to performing recommended exercises without supervision [1]. However, < 50% of women referred for PFPT complete their prescribed program [2]. In 2011 the International Continence Society convened a State-of-the-Science Seminar to review and summarize existing evidence and identify future research priorities related to PFPT adherence. This 17-member multidisciplinary expert panel published a “2014 Consensus Statement on Improving Pelvic Floor Muscle Training Adherence,” along with four related summary papers in which they identified six priority areas for future research and highlighted the lack of high-quality studies addressing this topic to date [3-7]. The aim of this study was to determine whether a multidisciplinary approach including physical therapy at initial urogynecology consultation resulted in increased adherence to prescribed PFPT.

In 2014 our team established a twice-monthly multidisciplinary Women’s Pelvic Wellness Clinic where patients can see multiple subspecialties (urogynecology, urology, colorectal surgery, clinical nutrition, and PFPT) in one location. Because this clinic has limited availability, all new referrals to urogynecology are triaged by a urogynecology provider who determines whether patients should be offered appointments in this multidisciplinary clinic or in our regular singlespecialty clinic. Those patients who will benefit from consultation with multiple subspecialists are offered their initial urogynecology appointment in this multidisciplinary clinic, often along with concurrent PFPT consultation. The objective of this study was to determine whether seeing a physical therapist at the time of initial urogynecologic consultation in a multidisciplinary setting increased adherence to PFPT referral and to identify factors associated with PFPT referral, attendance and therapy completion. We were also interested in exploring the relationship between the rate of surgical management of patients seen in multidisciplinary clinic versus those seen in a traditional clinic and those who attended PFPT versus those who did not. We hypothesized that rates of PFPT adherence would be higher when the patient met with a physical therapist at her initial urogynecology consultation as opposed to meeting with the urogynecologist alone.

Materials and methods

This study was reviewed and deemed exempt by our Health Sciences Minimal Risk Institutional Review Board (IRB). We performed a retrospective chart review of all new patients seen for urogynecology consultation during the 1-year period at our institution following establishment of the multidisciplinary Women’s Pelvic Wellness Clinic. We included all adult (> 18 years old) female patients seen as new patients by a urogynecology provider between February 1, 2014, and February 1, 2015, and excluded those who were deceased within a year of their initial consultation. Billing data were used to generate this comprehensive list of patients seen in our practice, and each patient was assigned a unique study identification number.

For each eligible patient, electronic medical records were reviewed to abstract data regarding (1) demographic information (age, race/ethnicity, insurance status, and zip code); (2) location and providers involved at initial urogynecologic consultation; (3) visit diagnoses; (4) PFPT referral, attendance, and completion; and (5) subsequent surgical management. Because our providers see patients in two separate healthcare delivery systems, we reviewed electronic medical records from both systems for each patient to maximize data capture regarding PFPT attendance and completion as well as surgical management. The media tabs in both systems were queried for scanned PFPT notes from outside providers as well. Abstracted data were maintained in a de-identified secure electronic database.

Those participants who were evaluated by a pelvic floor physical therapist at their initial urogynecologic consultation were categorized as “same-day PFPT” and those who saw a urogynecologist alone were categorized as “no same-day PFPT.” Participants were categorized according to clinic location in which their initial urogynecology consultation occurred (multidisciplinary versus standard, single specialty clinic). Patients were identified as having been referred to PFPT if an order was placed for PFPT consultation on the day of initial urogynecology consultation. Those patients who attended at least one PFPT visit (not including their same-day PFPT visit) were categorized as having attended PFPT. Those patients who had a discharge summary from PFPT or who attended at least three PFPT visits were categorized as having completed PFPT. Patients for whom no PFPT notes were identified in chart review were categorized as non-attenders. Distance from PFPT to patient residence was estimated based on calculated distance between zip codes and was categorized as < 10 miles versus ≥ 10 miles.

Descriptive statistics characterized the sample. Chi-square testing was used to compare rates of PFPT attendance and completion between those women who saw same-day PFPT and those who did not. Univariate and multivariate backward stepwise logistic regressions were used to identify factors associated with attendance, completion, and referral for PFPT. Those factors associated on univariate analysis with $p < 0.2$ were included in multivariate models; age was dichotomized as less than versus 65 years or older for these analyses. Chi-square testing compared rates of PFPT referral, attendance, completion, and surgery among those patients who were seen in a multidisciplinary clinic versus a standard, single specialty clinic and to compare rates of surgery among patients who did and did not complete a course of PFPT.

Analyses were performed using SPSS 22.0.

Results

Among the 981 patients identified in the initial medical records query, 98% (958/981) met criteria for inclusion, and 35% (335/958) of included patients were referred to PFPT (Fig. 1). Table 1 provides an overview of relevant demographic and clinical characteristics for the sample overall and stratified by PFPT referral, attendance, and completion. Of the 67% (225/335) of patients for whom data on distance from residence to PFPT were available, 60% (136/225) lived within 10 miles of PFPT.

Among the 335 patients referred to PFPT, 224 (67%) attended PFPT and 141 (42%) completed PFPT. Figure 2 displays rates of PFPT attendance and completion among the 335 patients referred to PFPT, stratified by whether they saw PFPT the same day as their initial urogynecology consult. Patients who saw PFPT the same day as their initial urogynecology visit were statistically significantly more likely to attend PFPT than those who did not (91% vs. 61%, $p < 0.001$), but completion rates did not differ significantly between the two groups (49% vs. 41%, $p = 0.15$).

Patients who were seen in multidisciplinary clinic were more likely to attend PFPT than those seen in a single specialty clinic (79% vs. 61%, $p = 0.001$) but completion rates did not differ significantly between the two groups (45% vs. 42%, $p = 0.337$).

Table 2 displays factors associated with PFPT attendance and completion on univariate and multivariate logistic regression. PFPT attendance was higher among women who saw a PFPT the same day as their initial urogynecology appointment ($p < 0.001$) and among those aged ≥ 65 years ($p = 0.015$). Age ≥ 65 years and white, non-Hispanic race/ethnicity were associated with PFPT completion.

PFPT referral rates were significantly higher among patients seen in our multidisciplinary clinic compared with those seen in a traditional clinic (55% vs. 29%, $p < 0.001$). Table 3 presents factors associated with referral to PFPT on logistic regression. Patients with a diagnosis of pelvic organ prolapse or urinary incontinence and those seen in multidisciplinary clinic were more likely to be referred to PFPT.

Data regarding surgery were available for 954 patients, of whom 16% ($n = 153$) had surgery following urogynecologic consultation. Women who did not attend PFPT were more likely than women who did attend PFPT to undergo surgery [6% (14/223) vs. 19% (139/731) ($p < 0.001$)]. However, among the group of patients referred to PFPT for whom data were available regarding surgery ($n = 326$), there was not a statistically significant difference ($p = 0.107$) in rate of surgery between those who attended PFPT (6%, 14/218) and those who did not (11%, 12/108). The rate of surgical management for patients seen in multidisciplinary clinic (14%, 30/214) was similar to that for patients seen in a traditional clinic (17%, 123/740, ($p = 0.211$).

Discussion

In this large series of women presenting for urogynecologic consultation, 35% overall were referred to PFPT, of whom 67% attended PFPT and 42% completed PFPT treatment. Concurrent consultation with pelvic floor physical therapy on the same day as initial urogynecologic consultation during a multidisciplinary assessment was associated with higher rates of PFPT attendance but not completion. Women aged ≥ 65 years and those who saw same-day PFPT were more likely to attend PFPT, while older and non-Hispanic white women were more likely to complete PFPT.

The rates of PFPT attendance and completion in our series are similar to those found by Shannon et al. in a 2018 retrospective review of urogynecologic patients in another Midwest academic practice setting (66 and 29%) [8] and in a subsequent 2019 randomized trial

testing the impact of enhanced counseling on PFPT attendance and completion (65 and 47%) [9].

These attendance and completion rates are higher than those found by Woodburn et al. in a 2019 review of patients referred to PFPT for high tone pelvic floor dysfunction (57 and 19%) [10]. The mean age of participants in this study was 44 years, and we found that patients > 65 years were more likely to both attend and complete PFPT, so perhaps this difference can be explained by the younger age of participants as well as their different urogynecologic diagnoses. Woodburn et al. also used a more stringent definition for PFPT completion than the one we used in our study.

Shannon et al. previously reported that women who identified as Hispanic in their 2018 retrospective review were less likely to initiate PFPT [8], while we found that non-Hispanic white women were more likely to complete PFPT. Sangi-Haghpeykar et al.'s 2008 survey of 200 Hispanic postpartum women in Texas found that only 20% of women received counseling about stress incontinence and PFPT during pregnancy or postpartum care [11]. In their study, women with less education and those whose primary language was Spanish were less likely to receive counseling; reasons for PFPT nonadherence included beliefs that PFPT would not help (47%) and not understanding the instructions (39%) [11]. These findings suggest that barriers to PFPT in different race/ethnicities, and particularly in women of Hispanic/Latinx/Spanish origin should be explored in future research.

PFPT attendance and completion are critical for maintaining effectiveness, yet rates of attendance and completion of prescribed PFPT are suboptimal [12]. The nature of adherence is complex, consisting of an interplay of over 200 factors including behavioral change, patient buy-in, and complexity and duration of the treatment [13]. Previously identified variables that impact adherence to PFPT include both individual self-efficacy [14, 15] and beliefs about the effectiveness of PFPT [11, 14] as well as discipline and motivation [16]. Previously noted barriers include difficulty remembering to do the exercises [17], being busy with work and childcare [18], and unfamiliarity or discomfort because of social taboos on continence [11, 19]. Incontinence severity may increase adherence [15], as may the strength of patient and practitioner partnership (dyadic cohesion) [14].

In our study, patients who received same-day PFPT were more likely than those who did not to attend subsequent PFPT visits. It is important to note that patients who received same-day PFPT in our clinic were specifically identified ahead of their initial visit because they carried referral diagnoses that were likely to benefit from PFPT. Patients seen in our singlesspecialty clinic did not have the opportunity to receive same-day PFPT even if the urogynecology provider determined that PFPT referral was appropriate at the time of that initial visit. It is possible that same-day PFPT consultation improved participant self-efficacy, beliefs about the effectiveness of PFPT, and dyadic cohesion, though we did not assess those constructs in this study. We also found that age > 65 years was associated with PFPT completion, a finding that may be related to this age group having fewer work and childcare responsibilities than younger women.

While it is likely that economic factors impact PFPT attendance and completion, determining individual costs to patients based on insurance types is complicated. Centers for Medicare and Medicaid reports that all costs associated with hospital-based outpatient physical therapy will be reimbursed if there is a need determined by the health care provider. However, nonhospital-based physical therapy will be covered only up to \$1860 annually [20]. In contrast to our study, where insurance type was not associated with PFPT attendance or completion, a cross-sectional survey of 213 Rhode Island women referred to PFPT for urinary incontinence found that not having insurance was a risk factor for nonparticipation, although patients with Medicare compared with private insurance were more likely to participate in PFPT [21]. Interestingly, in both our study and the Rhode Island cohort, distance from PFPT was not significantly associated with participation [21].

Our study is limited by its retrospective nature, the minimal racial and ethnic diversity in the cohort, the inclusion of patients from a single academic institution, and the lack of qualitative information regarding individual patients' reasons for not attending or completing physical therapy. The lack of random allocation of patients to same-day PFPT introduces the potential for selection bias, where patients who are more likely to benefit from PFPT are more likely to receive same-day PFPT, but this selective allocation also allows us to evaluate the impact of this intervention in the real-world setting, where we would not randomly allocate patients to PFPT referral. Additionally, our study uses appropriate statistical analyses to identify important factors associated with PFPT attendance and referral in a relatively large sample size and thus makes a strong contribution to a rather limited current body of literature addressing this research question.

In conclusion, adherence to PFPT is a critical component of non-surgical management of pelvic floor disorders, including urinary incontinence, overactive bladder, pelvic organ prolapse, and fecal incontinence. In this large series of women presenting for urogynecologic consultation, the opportunity to meet with a pelvic floor physical therapist at their initial consultation with their physician (same-day PFPT) in a multidisciplinary setting was associated with higher rates of PFPT attendance. However, initial multidisciplinary exposure did not affect rates of PFPT completion. While a multidisciplinary approach appears to promote PFPT attendance, further study is required to determine how we can positively affect adherence and completion with this important treatment approach.

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References

1. Hay-Smith EJ, Herderschee R, Dumoulin C, Herbison GP. Comparisons of approaches to pelvic floor muscle training for urinary incontinence in women. *Cochrane Database Syst Rev*. 2011;12:CD009508 10.1002/14651858.CD009508.
2. Tibaek S, Dehlendorff C. Do women with pelvic floor dysfunction referred by gynaecologists and urologists at hospitals complete a pelvic floor muscle training programme? A retrospective study, 1992-2008. *Int Urogynecol J*. 2013;24(8):1361–9. 10.1007/s00192-012-2018-2. [PubMed: 23291858]

3. Dumoulin C, Hay-Smith J, Frawley H, McClurg D, Alewijnse D, Bo K, et al. 2014 consensus statement on improving pelvic floor muscle training adherence: International Continence Society 2011 state-of-the-science seminar. *Neurourol Urodyn*. 2015;34(7):600–5. 10.1002/nau.22796. [PubMed: 25998603]
4. Dumoulin C, Alewijnse D, Bo K, Hagen S, Stark D, Van Kampen M, et al. Pelvic-floor-muscle training adherence: tools, measurements and strategies-2011 ICS state-of-the-science seminar research paper II of IV. *Neurourol Urodyn*. 2015;34(7):615–21. 10.1002/nau.22794. [PubMed: 25998493]
5. Frawley HC, McClurg D, Mahfooza A, Hay-Smith J, Dumoulin C. Health professionals' and patients' perspectives on pelvic floor muscle training adherence-2011 ICS state-of-the-science seminar research paper IV of IV. *Neurourol Urodyn*. 2015;34(7):632–9. 10.1002/nau.22774. [PubMed: 25998188]
6. Hay-Smith J, Dean S, Burgio K, McClurg D, Frawley H, Dumoulin C. Pelvic-floor-muscle-training adherence “modifiers”: a review of primary qualitative studies-2011 ICS state-of-the-science seminar research paper III of IV. *Neurourol Urodyn*. 2015;34(7):622–31. 10.1002/nau.22771. [PubMed: 25998067]
7. McClurg D, Frawley H, Hay-Smith J, Dean S, Chen SY, Chiarelli P, et al. Scoping review of adherence promotion theories in pelvic floor muscle training-2011 ICS state-of-the-science seminar research paper I of IV. *Neurourol Urodyn*. 2015;34(7):606–14. 10.1002/nau.22769. [PubMed: 25997975]
8. Shannon MB, Genereux M, Brincat C, Adams W, Brubaker L, Mueller ER, et al. Attendance at prescribed pelvic floor physical therapy in a diverse, urban urogynecology population. *PM R*. 2018;10(6):601–6. 10.1016/j.pmrj.2017.11.008. [PubMed: 29138041]
9. Shannon MB, Adams W, Fitzgerald CM, Mueller ER, Brubaker L, Brincat C. Does patient education augment pelvic floor physical therapy preparedness and attendance? A randomized controlled trial. *Female Pelvic Med Reconstr Surg*. 2018;24(2):155–60. 10.1097/SPV.0000000000000516. [PubMed: 29474290]
10. Woodburn KL, Tran MC, Casas-Puig V, Ninivaggio CS, Ferrando CA. Compliance with pelvic floor physical therapy in patients diagnosed with high-tone pelvic floor disorders. *Female Pelvic Med Reconstr Surg*. 2019 10.1097/SPV.0000000000000732.
11. Sangi-Haghpeykar H, Mozayeni P, Young A, Fine PM. Stress urinary incontinence and counseling and practice of pelvic floor exercises postpartum in low-income Hispanic women. *Int Urogynecol J Pelvic Floor Dysfunct*. 2008;19(3):361–5. 10.1007/s00192-007-0438-1. [PubMed: 17701092]
12. Kim H, Yoshida H, Suzuki T. The effects of multidimensional exercise treatment on community-dwelling elderly Japanese women with stress, urge, and mixed urinary incontinence: a randomized controlled trial. *Int J Nurs Stud*. 2011;48(10):1165–72. 10.1016/j.ijnurstu.2011.02.016. [PubMed: 21459381]
13. Haynes RB, Taylor D, Sackett DL. Compliance in health care. Baltimore: The Johns Hopkins University Press; 1979.
14. Chen SY, Tzeng YL. Path analysis for adherence to pelvic floor muscle exercise among women with urinary incontinence. *The journal of nursing research : JNR*. 2009;17(2):83–92. 10.1097/JNR.0b013e3181a53e7e. [PubMed: 19516102]
15. Alewijnse D, Mesters I, Metsemakers J, Adriaans J, van den Borne B. Predictors of intention to adhere to physiotherapy among women with urinary incontinence. *Health Educ Res*. 2001;16(2):173–86. [PubMed: 11345660]
16. Hahn IMI, Fall M, Ekelund P. Long-term results of pelvic floor training in female stress urinary incontinence. *Br J Urol*. 1993;72: 421–7. [PubMed: 8261297]
17. Gallo MLSD. Cues to action: pelvic floor muscle exercise compliance in women with stress urinary incontinence. *Neurourol Urodyn*. 1997;16:167–77. [PubMed: 9136139]
18. Lagro-Janssen ALMSA, Wan Weel C. Favourable effects of exercise therapy for urinary incontinence in the family practice especially dependent on adherence and motivation. *Nederlands Tijdschrift voor Geneeskunde*. 1994;138:1273–6.
19. Ashworth PDHM. Some social consequences of non-compliance with pelvic floor exercises. *Physiotherapy*. 1993;79:465–71.

20. Center for Medicare and Medicaid Services (CMS) Extension of the therapy cap exceptions process: CMS public use files. 2010 <http://www.cms.gov/therapyservices>. Accessed 2 Aug 2010.
21. Washington BB, Raker CA, Sung VW. Barriers to pelvic floor physical therapy utilization for treatment of female urinary incontinence. *Am J Obstet Gynecol*. 2011;205(2):152.e151–9. 10.1016/j.ajog.2011.03.029. [PubMed: 21620356]

Fig. 1.
CONSORT diagram

Fig. 2.
Rates of attendance and completion of pelvic floor physical therapy (PFPT) with and without same-day PFPT appointment at initial urogynecology consultation

Table 1

Sample description stratified by pelvic floor physical therapy (PFPT) outcomes

Characteristic	Sample overall N = 958 n (%)	Referred to PFPT N = 335 n (%)	Attended PFPT N = 224 n (%)	Completed PFPT N = 141 n (%)
Age in years [mean (SD)]	57.7 (16.6)	57.7 (15.8)	59.0 (15.5)	61.7 (15.9)
Race/ethnicity ^a				
African American/Black	21 (2)	9 (3)	5 (2)	1 (1)
Am. Indian/Hawaiian Native	8 (1)	1 (0)	1 (0)	0 (0)
Asian	13 (1)	6 (2)	3 (1)	2 (1)
Hispanic/Latinx/Spanish descent	25 (3)	5 (2)	2 (1)	2 (1)
White	896 (94)	313 (93)	214 (96)	137 (97)
Marital status				
Married/partnered	567 (59)	208 (62)	138 (62)	92 (66)
Single/never married	191 (20)	61 (18)	38 (17)	19 (14)
Divorced/separated	99 (10)	36 (11)	26 (12)	13 (9)
Widowed	96 (10)	29 (9)	22 (10)	17 (12)
Insurance status				
Medicare/Medicaid	434 (45)	143 (43)	97 (44)	68 (49)
Private	524 (55)	192 (57)	126 (57)	73 (51)
Urogynecologic diagnoses				
Pelvic organ prolapse	395 (41)	182 (54)	124 (55)	80 (57)
Urinary incontinence	646 (67)	288 (86)	193 (86)	122 (87)
Clinic type				
Multidisciplinary	216 (23)	119 (36)	93 (42)	53 (38)
Single specialty	742 (78)	216 (65)	131 (59)	88 (62)
Same-day physical therapy	74 (8)	74 (22)	67 (30)	36 (26)

^a Participants were asked about race and ethnicity separately so numbers do not sum to 100%

Table 2

Factors associated with pelvic floor physical therapy (PFPT) attendance and completion

Factor	PFPT attendance		PFPT completion	
	Odds ratio (95% CI) ^a	Adjusted odds ratio (95% CI)	Odds ratio (95% CI)	Adjusted odds ratio (95% CI)
Age 65 years	1.02 (1.00, 1.03)	1.01 (0.999, 1.03)	1.03 (1.01, 1.04)	1.03 (1.01, 1.04)
White, non-Hispanic	2.60 (1.16, 5.81)	–	2.65 (1.03, 6.78)	2.26 (0.87, 5.89)
Married	0.99 (0.60, 1.55)		1.28 (0.81, 2.01)	
Government insurance	1.11 (0.70, 1.76)		1.50 (0.97, 2.33)	–
Pelvic organ prolapse	1.13 (0.72, 1.79)		1.18 (0.76, 1.83)	
Urinary incontinence	1.07 (0.56, 2.06)		1.11 (0.59, 2.08)	
Multidisciplinary clinic	2.39 (1.42, 4.01)	–	1.13 (0.72, 1.78)	
Same-day PFPT	6.22 (2.75, 14.08)	6.03 (2.66, 13.69)	1.36 (0.81, 2.29)	
PFPT within 10 miles	1.55 (0.31, 7.84)		1.32 (0.76, 2.29)	

Data in bold have $p < .05$ ^a CI confidence interval

Table 3

Factors associated with pelvic floor physical therapy (PFPT) referral

Factor	Odds ratio (95% CI) ^a	Adjusted odds ratio (95% CI)
Age 65 years	1.00 (0.99, 1.01)	
White, non-Hispanic	1.15 (0.71, 1.87)	
Married	1.20 (0.92, 1.58)	–
Government insurance	0.85 (0.65, 1.11)	
Pelvic organ prolapse	2.29 (1.75, 3.00)	2.26 (1.69, 3.02)
Urinary incontinence	4.54 (3.21, 6.42)	4.41 (3.08, 6.31)
Multidisciplinary clinic	2.99 (2.19, 4.08)	3.03 (2.17, 4.23)
PFPT within 10 miles	1.53 (0.09, 24.75)	

Data in bold have $p < .05$ ^a CI confidence interval