

The Quality of Care Provided to Women with Urinary Incontinence in 2 Clinical Settings



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Abbreviations and Acronyms

ICS = International Continence Society

MSG = multispecialty medical group

PVR = post-void residual urine

QI = quality of care indicator

SUI = stress UI

UI = urinary incontinence

UUI = urge UI

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Purpose: Our aim was to test the feasibility of a set of quality of care indicators for urinary incontinence and at the same time measure the care provided to women with urinary incontinence in 2 clinical settings.

Materials and Methods: This was a pilot test of a set of quality of care indicators. A total of 20 quality of care indicators were previously developed using the RAND Appropriateness Method. These quality of care indicators were used to measure care received for 137 women with a urinary incontinence diagnosis in a 120-physician hospital based multispecialty medical group. We also performed an abstraction of 146 patient records from primary care offices in Southern California. These charts were previously used as part of ACOVE (Assessing Care of Vulnerable Elders Project). As a post-hoc secondary analysis, the 2 populations were compared with respect to quality, as measured by compliance with the quality of care indicators.

Results: In the ACOVE population, 37.7% of patients with urinary incontinence underwent a pelvic examination vs 97.8% in the multispecialty medical group. Only 15.6% of cases in the multispecialty medical group and 14.2% in ACOVE ($p = 0.86$) had documentation that pelvic floor exercises were offered. Relatively few women with a body mass index of greater than 25 kg/m² were counseled about weight loss in either population (20.9% multispecialty medical group vs 26.1% ACOVE, $p = 0.76$). For women undergoing sling surgery, documentation of counseling about risks was lacking and only 9.3% of eligible cases (multispecialty medical group only) had documentation of the risks of mesh.

Conclusions: Quality of care indicators are a feasible means to measure the care provided to women with urinary incontinence. Care varied by population studied and yet deficiencies in care were prevalent in both patient populations studied.

Key Words: urinary bladder; urinary incontinence; female urogenital diseases; quality indicators, health care; quality of health care

As medical costs have risen, the need to decrease costs of health care while improving the quality of the care has made the investigation of appropriate

effectiveness of medical and surgical interventions a priority in health services research.¹⁻³ To that aim, QIs have been developed to investigate

the quality of care for various diseases.^{4–6} Unlike clinical guidelines, which measure optimal care, quality indicators outline the minimum care appropriate for a patient with a specific condition. If an element of care, as measured by a quality indicator, is not performed, then such care would be considered inadequate.⁷

UI has been defined by ICS as “the complaint of any involuntary leakage of urine.”⁸ Approximately 11% of all women will undergo surgery for UI or pelvic organ prolapse by age 80 years and of these women 29% will require a reoperation for recurrent symptoms.^{9,10} As part of the ACOVE project at RAND Corp., QIs were developed for community dwelling adults 65 years old or older.¹¹ QIs specifically designed for vulnerable community dwelling adults with UI were used to assess the records of a total of 372 randomly selected patients enrolled in 2 senior managed care plans who were identified to be at risk for functional decline.¹² A pelvic examination was performed in only 20% of women, only 50% of patients received medical treatment for incontinence and only 13% were prescribed behavioral intervention, despite its proven effectiveness.¹²

While these findings from ACOVE identified poor quality of care for UI in older patients, there remains a lack of data in women more likely to undergo surgical procedures for UI, including younger women and older women with relatively good health. The objective in this study was to use our recently developed QIs to test their feasibility and, at the same time, measure the care provided to women with UI in 2 clinical settings.

MATERIALS AND METHODS

QI Development

Building on ACOVE, we previously developed and validated a set of 27 process based QIs to measure the care provided to women with UI in generalist and specialist settings.¹³ Briefly, we developed and ranked a set of QIs that address prevention, screening, diagnosis, workup, and nonsurgical and surgical management (supplementary Appendix, <http://jurology.com/>). These QIs were developed using the UCLA-RAND Appropriateness (Delphi) method, a widely used method for synthesizing evidence and expert judgment to produce QIs.^{14–16} A panel of 9 experts from the fields of urogynecology, urology and internal medicine ranked the validity and feasibility of the proposed QIs on a 9-point scale with 1 representing “definitely not valid” and 9 representing “definitely valid.”¹² We then convened an in-person panel and moderated discussions regarding the advantages and disadvantages of each QI, after which each panelist re-ranked the validity of each QI (supplementary Appendix, <http://jurology.com/>). Although the panel ranked QIs on feasibility, it was validity scores that

determined inclusion in the final set of indicators. The true test of feasibility is if 1) the QI is identifiable in the medical record and 2) this recorded information is likely to be reliable.

Study Populations

We performed a pilot test of these candidate QIs to determine feasibility by abstracting records in 2 health care systems. First, we abstracted 146 de-identified patient charts previously used in ACOVE from primary care offices caring for older adults (age 65 years or greater) at risk for functional decline with a diagnosis of UI in the Southern California area.^{7,11,12} Patients were previously identified as a vulnerable elder by a vulnerable elders survey, which asked about self-rated health, limitations in physical function, age group and functional disabilities. These records included the notes of any specialists seen and any related procedure or operative notes. Therefore, the care measured included that of all physicians treating the patient. As long as the necessary care was given to the patient, it did not matter which provider gave the care to the patient.

For our second population, we reviewed 287 charts from all women diagnosed with UI and treated between April 2010 and September 2011 from a 120-physician hospital based MSG in Los Angeles. In addition to primary care providers, this MSG had 3 fellowship trained female pelvic medicine specialists (2 urologists and 1 urogynecologist), 6 general gynecologists and 2 urologists who provided the care to the patients in the cohort. For this population a retrospective chart abstraction of electronic health records was performed by trained nurses with experience in chart abstraction and quality assessment. This time frame marked the first 18-month period after the launching of a new hospital based electronic health system (Epic Systems, Verona, Wisconsin). From this set, 137 cases were identified as having documented new or worsening symptoms of UI of any kind in the medical record (vs stable/prevalent UI, improving UI or UI attributable to infection) and were included in study. We applied our proposed QIs to measure compliance with the indicators in both settings. As a post-hoc secondary analysis, we also assessed variation in care between the 2 clinical settings.

The study received Cedars-Sinai Medical Center institutional review board approval (#PRO00023654).

Outcome Measures

Our primary outcome measures were compliance with our set of QIs and aggregate scores. Compliance with a QI was defined as at least 1 provider documenting the delivery of the indicated care to the patient. As described by McGlynn et al, the number of times a patient was counted in the denominator depended on the number of providers who saw the patient and could have performed the specified process.¹⁶ A passing score was given if at least 1 of the patient providers delivered the indicated care. In order to produce aggregate scores, we divided all encounters in which recommended care was given by the number of times that patients were eligible for specific indicators in a 6-month time period. Aggregate scores were reported as a percentage.

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