

# Management of Menopause and Midlife Health Issues: What Do Midlife Women Want from Primary Care Clinicians?

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## Introduction

As the Baby Boomers move into their 50s and 60s, a larger proportion of Kaiser Permanente (KP) members will be menopausal women. Menopause and midlife have many potential short-term and long-term health consequences, including heart disease, osteoporosis, and physical and emotional symptoms of low estrogen levels. Even if menopause and midlife do not have dramatic health consequences for individual women, many women at this stage of life are looking for strategies to stay healthy or to become healthier. How well KP meets these health care needs has implications for how KP is viewed by its members and by the community at large.

KP's new "Thrive!" marketing strategy focuses on wellness and total health and dovetails with the needs of many midlife women.<sup>1</sup> Wellness is a focus that includes a broad range of issues of concern to patients but not necessarily physicians: physicians are expert in acute care but not necessarily expert in preventive care. In short, our future success depends on KP's ability to address wellness issues—such as menopause and midlife health—with our current and prospective patients.

For example, women want to learn about menopause and their health care options<sup>2,3</sup> but are not receiving the information and consultation they need.<sup>4</sup> Of 665 women in a recent survey, more than half left their medical appointments with unanswered questions about menopause and hormone therapy (HT). Women understood the symptoms of menopause but not its long-term health risks.<sup>5</sup>

KP members also want more information than they have been receiving from clinicians.<sup>6</sup> Women reported fears about aging and illness; wondered whether to seek care for vague symptoms; and were displeased that clinicians tended to trivialize symptoms. The researchers

concluded that the women lacked understanding of normal menopause and did not know what to expect. Most women were interested in relieving symptoms and in preventing future illness and wanted individualized treatment based on their personalized risk assessment.

Recent KP efforts to inform women about menopause have included use of individualized appointments with a Menopause Nurse Practitioner; development and distribution of the *Menopause Guidebook*;<sup>7</sup> availability of menopause classes and group appointments; and mass mailings of a one-page information pamphlet. These programs were somewhat successful but either showed limited scope or engendered only partial recall in female readers because the written information was not reinforced or personalized by a clinician's endorsement. This KP experience shows that to be successful an intervention must be focused, personalized, and reach a high percentage of perimenopausal and menopausal women. Such an intervention can take place only during an office visit—the only strategy that can 1) improve women's understanding of menopause, 2) provide personalized information and care, and 3) reach a high percentage of women in the targeted age group.

Although menopause is widely considered to be best addressed in the Gynecology Department, this approach misses many women in the targeted age group. In the KP Northern California (KPNC) Region, a two-year study of utilization patterns<sup>8</sup> of female Kaiser Foundation Health Plan members aged 45 to 57 years showed that of 6000 women, about 6% were seen only in the Gynecology Department, 60% were seen in both the Gynecology and Internal Medicine Departments, and 25% were seen only in the Internal Medicine Department. In a one-year period, 34% of the same women visited the Internal Medicine but not the Gynecology Department,

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and nearly 37% were seen in both departments. Focusing an intervention in Gynecology Departments would probably exclude women who visit their gynecologists less often over time. KP focus groups have indicated that women who are more accustomed to speaking with gynecology clinicians about menopause would nonetheless be willing to speak with a knowledgeable medicine clinician.<sup>6</sup>

This study—the Management of Menopause Intervention (MOMI) study—asked whether a systematic, office-based intervention in a primary care setting—in particular, the Internal Medicine and Gynecology Departments—could achieve three goals:

- Improve midlife women's understanding and confidence about menopause and midlife health issues;
- Improve midlife women's satisfaction with their health care; and
- Improve clinicians' awareness and apparent competence to counsel midlife female patients about their health.

## Methods

The MOMI Study was a three-pronged intervention that consisted of the following components:

- Clinician education in menopause and midlife health;
- A multipart intervention—called FLASH—consisting of a self-test questionnaire; patient handouts on menopause and midlife health issues; and brief clinician-patient counseling; and
- Systematic prompts for clinicians to use the intervention.

These components were implemented between June 2003 and July 2004. The study protocol was approved by the KPNC Institutional Review Board. The analysis reported in this article is based on survey results that addressed the first two goals of the study—whether FLASH could improve midlife women's understanding and confidence about menopause and midlife health issues and improve midlife women's satisfaction with their health care. To analyze these goals, we compared survey results of women who did and who did not receive the FLASH intervention during their most recent visit. We also examined whether the effect of FLASH differed among women who received the intervention in the Internal Medicine Department or in the Gynecology Department.

## Study Participants

Women aged 45 to 55 years who were assigned to the KP Richmond Medical Center—about 5300 women—were eligible for the study. All women who came in for

The figure shows a questionnaire titled "Hot Flash Women's Midlife Health Check" from Kaiser Permanente. It is divided into four main sections: Menopausal Symptoms, Heart Health, Bone Health, and Breast Health. Each section contains a list of questions with checkboxes for "Yes" and "No".

- Menopausal Symptoms:**
  - Do you have irregular periods or have you stopped having periods? (Yes/No)
  - Do you have hot flashes or night sweats? (Yes/No)
  - Do you have trouble sleeping? (Yes/No)
  - Do you have vaginal dryness? (Yes/No)
  - Do you experience the changes in your sexuality? (Yes/No)
  - Do you often feel nervous, irritable, or tense? (Yes/No)
  - Do you often feel down, blue, or depressed? (Yes/No)
- Heart Health:**
  - Do you smoke? (Yes/No)
  - Why do you physically inactivate? (Yes/No)
  - Are you overweight? (Yes/No)
  - Do you have diabetes? (Yes/No)
  - Do you have high cholesterol? (Yes/No)
- Bone Health:**
  - If you are over 50, have you broken a bone since you turned 50? (Yes/No)
  - Do you weigh less than 100 pounds? (Yes/No)
  - Do you smoke? (Yes/No)
  - Do you exercise less than 3 times a week? (Yes/No)
  - Do you eat at least dairy products less than 3 times a day? (Yes/No)
- Breast Health:**
  - Have you had a mammogram in the past two years? (Yes/No)
  - Do you have a family history of breast cancer? (Yes/No)

There are also boxes for "MDSP Advice Referral" and "MDSP" information at the bottom right.

Figure 1. "Health Flash" questionnaire.

any type of daytime visit (except for preoperative appointments) to the Internal Medicine or Gynecology Department between September 2, 2003, and December 1, 2003, were eligible for the patient survey upon which this analysis is based.

## Clinician Education

Physician training about menopause is standard in most gynecology residencies but not in internal medicine residencies. Moreover, current opinion among clinicians concerning menopause and HT is changing rapidly,<sup>9</sup> and even experienced clinicians may have outdated or inadequate knowledge. Further, even if sufficiently trained about menopause, many clinicians may not have practiced brief, personalized counseling techniques. To help with these deficits, quarterly facilitywide grand rounds directly addressed aspects of this broad topic such as osteoporosis, alternative treatment for menopausal symptoms, and the relation between HT and heart disease.

Small training sessions were organized within each department to train clinicians in the use of the questionnaire, associated information packet, and techniques of brief midlife health counseling. Use of the materials and implementation success were continuously assessed by clinician feedback collected quarterly.

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### Components of the FLASH Intervention

A "Health Flash" questionnaire (Figure 1) was designed, printed on triplicate paper, and used with a packet containing women's midlife health information covering menopause, osteoporosis, calcium, and group menopause class information (materials already in use in KPNC). A "Women and Heart Disease" tipsheet was specifically designed for the study and was included in the packet.

Clinicians in the Internal Medicine and Gynecology Departments were taught to deliver a brief (1- to 5-minute) counseling message to women as part of their health care visit, to be used with the FLASH questionnaire and information packet. This counseling was expected to be done at least once per year for each eligible woman visiting either the Gynecology or Internal Medicine Department.

### Systematic Prompt for Clinicians

To automatically prompt clinicians in Internal Medicine and Gynecology Departments to discuss midlife health and menopause with midlife female patients, a medical assistant or receptionist attached the FLASH questionnaire and packet to the charts of women aged 45 to 55 years who presented for primary care services. The clinician reviewed questionnaire responses and discussed recommended interventions (eg, testing, medications, or dietary adjustment) with the patient. To reinforce the counseling received, the patient was given a copy of the form and a record of additional recommended resources or tests. Another copy was placed in the patient's chart, and a third copy was kept for project documentation.

### Survey Method

Improvement in women's understanding and confidence about menopause and their satisfaction with their health care were measured by using a telephone survey ("patient survey"). Patients were stratified into four groups according to whether they visited an internal medicine or gynecology clinician and whether they received the FLASH intervention. A random sample of women was selected from each group (but all patients who received FLASH in the Gynecology Department were included because the group was small). The survey took approximately 10-15 minutes to complete and asked about clinicians' quality and thoroughness of care as well as patients' satisfaction with the counseling and information received regarding menopause, osteoporosis, and heart disease. Within a month after their health care visit, women were called for the patient survey by an independent telephone survey vendor.

### Statistical Analysis

Bivariate and multivariate analyses tested for statisti-

cally significant and substantively meaningful differences in FLASH and non-FLASH respondents. Multivariate statistical models were used to control for demographic differences when testing for statistically significant differences in performance.

### Results

#### Who Received FLASH

FLASH was received by 10% of eligible patients seen in the Internal Medicine Department and 15% of eligible patients seen in the Gynecology Department.

For the four groups of women surveyed, survey responses were completed by 59 (82%) of GYN patients who received FLASH, 105 (77%) of GYN patients who did not receive FLASH, 146 (90%) of MED patients who received FLASH, and 103 (60%) of MED patients who did not receive FLASH.

The survey showed that patients who self-reported going through menopause or beginning to experience menopause symptoms were not more likely to have received the FLASH intervention. Among patients seen in the Internal Medicine Department, 26% of those who received the intervention and 10% of those who did not receive the intervention indicated that they had already gone through menopause. This difference between groups was significant ( $p < .05$ ). Similarly, patients who were seen in the Internal Medicine Department and received the intervention were older (mean age 50.2 years) than patients who were seen in that department and did not receive the intervention (mean age 48.3 years) ( $p < .05$ ). Patients seen in the Gynecology Department showed no such pattern.

White patients were statistically significantly more likely to receive the intervention than were African-American patients. White women constituted 38% of women who received FLASH but only 27% of women who did not receive FLASH ( $p < .05$ ). In contrast, African-American women constituted only 26% of women who received FLASH but constituted 38% of women who did not receive FLASH ( $p < .05$ ). This difference persisted even after controlling for women's age, education, and stage of menopause as well as department visited and patient's familiarity with the clinician seen. The same proportions of Asian and Latina women did and did not receive FLASH.

Among patients seen in the Internal Medicine Department, women receiving the intervention were more likely to have visited a clinician who they regularly see than were women who did not receive the intervention (91% versus 79%,  $p < .05$ ). Clinicians' use of the intervention was not statistically correlated with individual clinician scores recorded for the KP Member Satisfaction Survey (MPS),<sup>10</sup> the ongoing patient satisfaction survey con-

ducted in KPNC. That is, clinicians with higher MPS scores were not more likely to use FLASH with their patients than were clinicians with lower MPS scores.

### Effect of MOMI on Patients

In both the Internal Medicine and Gynecology Departments, bivariate analysis showed that MOMI increased the likelihood of clinicians discussing menopause, heart disease, and osteoporosis with patients and of giving them written information (Table 1).

Bivariate analysis also showed that among patients seen in the Internal Medicine Department, those who received FLASH reported a higher level of satisfaction with the amount of time the clinician spent with them compared with non-FLASH patients (83% versus 68% reporting a satisfaction score of 8, 9, or 10) and a higher level of satisfaction with the medical care they received during the visit (84% versus 73% reporting a satisfaction score of 8, 9, or 10). FLASH did not have a statistically significant impact on these satisfaction measures for the patients seen in the Gynecology Department.

Because the strong associations in the bivariate analysis might be explained by other factors, we used multivariate analysis to control for several possible covariates, including familiarity with the clinician seen; patient's stage of menopause and education; race, ethnicity; and clinicians' patient satisfaction scores. Even after controlling for these factors, women who received FLASH during a visit to the Internal Medicine Department were still more likely than women who did not receive FLASH to have discussed menopause and osteoporosis with their clinician and were more likely to have received written materials about menopause. Moreover, women who received FLASH in the Internal Medicine Department remained more satisfied with the amount of time their clinician spent with them and with the medical care they received.

In the multivariate analysis of gynecology patients' responses, we found that women who received FLASH were still more likely than women who did not receive FLASH to have discussed osteoporosis with their clinicians and to have received written material about menopause. However, the likelihood of discussing menopause or heart disease no longer differed between these two groups.

### Discussion

Only about 10% of eligible patients visiting the Internal Medicine Department and 15% of eligible patients visiting the Gynecology Department received the intervention during the time when the patient survey was fielded. Most clinicians used the FLASH interventions infrequently because clinicians did not receive the inter-

**Table 1. Percentage of women who did and who did not receive the FLASH intervention in the Internal Medicine and Gynecology Departments**

	Internal Medicine		Gynecology	
	FLASH	No FLASH	FLASH	No FLASH
Clinician discussed menopause	63 <sup>a</sup>	26	88 <sup>a</sup>	72
Clinician discussed heart disease	46 <sup>a</sup>	32	43 <sup>a</sup>	26
Clinician discussed osteoporosis	37 <sup>a</sup>	14	64 <sup>a</sup>	32
Patient received written information on menopause	75 <sup>a</sup>	30	80 <sup>a</sup>	53

<sup>a</sup> Within the Internal Medicine and Gynecology Departments, FLASH patients answered significantly differently than patients who did not receive FLASH ( $p < .05$ ).

vention packet and questionnaire consistently. In both departments, virtually all clinicians using the intervention wanted a better process for systematizing the distribution. Unlike a pediatric department, which typically maintains various age-related handouts that constitute a standard part of most pediatric visits, neither the Internal Medicine nor the Gynecology Department was accustomed to using such an automatic process. A better system probably would have led to more women receiving the FLASH intervention.

This study cannot fully explain why particular patients received or did not receive FLASH. Because the distribution system and clinician prompts were suboptimally effective and not systematic, findings regarding the relation between patients who received FLASH and menopausal status and race cannot be reliably explained.

We initially hypothesized that clinicians who used FLASH—that is, clinicians who routinely gave additional information on menopause—might also have higher baseline patient satisfaction scores (ie, MPS scores) than other clinicians. We were surprised to observe that MPS scores did not predict which patients received the intervention. The suboptimal implementation system for automatically distributing FLASH to eligible patients may have overshadowed a relationship between clinicians' MPS scores and use of FLASH. Therefore, we cannot completely rule out the possibility that clinicians who were more likely to talk with women about menopause, heart disease, and osteoporosis before MOMI may have been more likely to use the FLASH intervention.

We were surprised by the sizable impact on patient satisfaction with length of visit and on patient satisfaction with medical care received among FLASH patients seen in the Internal Medicine Department, even after controlling for clinicians' scores on MPS. This effect was not observed in patients seen in the Gynecology Department. This difference may be explained by the relatively few women in the Gynecology Department samples and because FLASH and non-FLASH Gynecology Department

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patients gave clinicians overall high scores on these measures, making any difference difficult to discern.

### Study Limitations

As discussed above, during the patient survey, the FLASH intervention was received by only about 10% of eligible women who visited the Internal Medicine Department and by only 15% of eligible women who visited the Gynecology Department.

Although we actively solicited clinicians' cooperation by involving them in several aspects of the project—developing the final format of the FLASH questionnaire and packet content; regularly presenting project progress and preliminary responses from patients; and obtaining endorsement by investigators in internal medicine and gynecology—some clinicians believed that adding FLASH to the clinic visit was inconvenient or that it was not valuable. Moreover, neither the support staff nor the clinicians had a systematic prompt to ensure distribution of the questionnaire. Distribution of the questionnaire relied on daily lists of eligible patients supplied by the project manager or individual staff members who remembered to distribute the questionnaire. In day-to-day clinic activities, FLASH was often forgotten.

### Conclusion

In both the Internal Medicine Department and the Gynecology Department, MOMI increased the likelihood of clinicians discussing menopause, heart disease, and osteoporosis with patients and of giving them written information. These findings suggest that a combination of prompted, automatic patient counseling, handout intervention, and clinician training increases the likelihood that a clinician will discuss midlife health issues with patients during a primary care office visit. In the hectic and time-limited primary care office visit, MOMI can help clinicians interactively deliver a brief, targeted preventive message about menopause to patients. The finding of improved satisfaction with their medical care among patients receiving FLASH in the Internal Medicine Department emphasizes that patients want such preventive information.

The impact of MOMI on midlife women's self-reported understanding and confidence about menopause and midlife health issues will be better measured when complete results of the preintervention and postintervention member survey become available. Meanwhile, the MOMI investigators/researchers hope that this study will provoke further discussion on how to deliver health care that embodies the larger health goal of KP's "Thrive" mission—health care based not only on acute and chronic care but also on wellness and preventive care. ❖

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