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# The Women's Life Center: Menopause Clinics Help Provide Quality Care and Education

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*Editor's Note: This article relates a single institution's experience in opening a menopause clinic. Our purpose in presenting this article is to share that experience and to encourage others to share with our readers any similar experiences they have had with starting new programs or initiating outreach efforts.*

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## Introduction

The number and percentage of women in the menopausal years is steadily increasing. The U.S. Census Bureau estimates that by the year 2010, more than 52 million women will be age 50 or older, accounting for 34% of the female population.<sup>1</sup> Despite this, only 9% of the women presenting to our ambulatory center (the Women's Ambulatory Health Service [WAHS] at Hartford Hospital in Hartford, CT) were age 50 or older. This disproportionately low statistic was of concern for two reasons. First, it implied that many menopausal women in our predominantly Latina population might not realize the need to be seen during this important phase of their lives. Second, it highlighted a gap in the education we were providing to our medical residents.

Many former residents now note how commonly they are faced with menopause-related issues in private practice, much more so than during their residency. Because of the small menopausal population in our resident continuity practices, many of those former residents were not motivated to learn about this important area of medicine and, hence, were developing a hindsight realization of their need for more experience and exposure during their training years.

Our goal in starting a menopause center was to address the unmet needs of our patients and to educate residents before

they are faced with the real-world realities of menopause-related issues.

## Evaluating Ourselves

Our center had recently gone through a transition that helped us evolve into an award-winning Women's Center.<sup>2</sup> Despite our success in reaching teens, young adults, and women with chronic conditions, we felt we were losing touch with women who were beyond their childbearing years. While Hartford Hospital serves a population with broad ethnic and economic backgrounds, the WAHS cares for a predominantly inner-city patient population. Our patient mix consists of approximately 60% Latina, 20% African-American, 15% Caucasian, and 5% from various other ethnic backgrounds. The number of Latina women in Connecticut doubled between 1980 and 1998, and is expected to double again by the year 2015. Additionally, Latina women have the lowest incomes of all women in Connecticut.<sup>3</sup>

We strive to provide affordable and quality care to all our patients, including the underserved, lower-income, inner-city population. We provide comprehensive prenatal, gynecologic, and primary care to more than 8,000 women of all ages, with more than 30,000 visits per year.

## Establishing the Center

The process of establishing the new center involved taking a close look at our cur-

rent resources, determining the needs of the population we hoped to serve, examining different funding options, and selecting a model for the care we hoped to provide (which also involved ensuring that we wouldn't be duplicating services provided by any other practices in the same geographic area).

*Taking Inventory.* Although some centers are designed entirely around menopausal women, we realized that we could establish a menopause specialty service within our WAHS, utilizing the strengths already in existence. We were fortunate to already have a very effective, efficient and successful practice, and therefore did not need to recreate our entire center.

Our academically based women's center utilizes 10,000 square feet of hospital space. We have 20 residents who have their continuity practices one day per week, supervised by three full-time generalist OB/GYN physicians. Additionally, we have three gynecologic and two primary care advanced practice RNs (APRNs), along with two midwives to assist with providing care. The center is divided into three smaller teams, or sub practices, to improve continuity and patient/provider satisfaction. One team is staffed entirely by residents, one team by mid-level practitioners, and one team has a combination of residents and APRNs. We have a treatment room that allows us

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to handle acute, but nonemergent, problem visits. A full-time ultrasonographer is present, and each of our teams has ultrasound equipment for resident use; this allows for comprehensive gynecologic and obstetrical ultrasound services.

We have our own pharmacy, social workers, nutritionists, an HIV/STD counselor, a domestic violence counselor, and financial counselors. We have several staff designated to assist with community outreach, including the promotion of abstinence, health outreaches to teens, screening services to identify families at risk for child abuse, and programs to reach women early in their pregnancies. A separate area, fully staffed and equipped, allows us to provide specialty services, including a colposcopy and a preoperative clinic.

Our goal was to recruit menopausal women who were not currently receiving care, and to provide consultation and education specific to menopausal women. We wanted to assure that they were getting evidence-based advice and that their health screening was complete and up to date.

By establishing a consultation service one afternoon per week, we were able to use our specialty service center where we also had our colposcopy and preoperative clinics. We were able to utilize the resources available through our ambulatory center, including nurses, counselors and educators. This meant we needed only a secretary and patient-care assistant with translation skills for this extra half-day per week activity.

*Information-Finding Phase: Surveying the Population.* As we progressed in our planning phase, the WAHS staff conducted an informal survey at several community health fairs and inner-city outreach centers. We surveyed women from the population we serve in an attempt to determine the need for our proposed service, the barriers to care, and the topics that would be important for education. All of the women consented to participate and were asked questions by several trained

**Table 1.**  
**Demographics of Women Surveyed (n=78)**

Age	%	Ethnicity	%	Language	%
25-30	1	Latina	72	Spanish only	77
31-40	18	African-American	17	English & Spanish	19
41-50	28	White	11	English only	4
51-60	18				
61-70	24				
> 70	11				

female staff members regarding demographic information, places where they currently received health care, factors that made it difficult for them to receive care, and health-related issues that concerned them.

Of the 78 women surveyed, 99% were over age 30, 82% were older than 40; 72% were Latina and 17% were African-American (Table 1). We found that mature women in our community were most interested in learning about osteoporosis, cardiovascular health, nutrition, and hormone replacement therapy (Table 2). Additionally, we found that the major barriers to receiving care were cost of medications, language barriers, transportation, and the cost of the visit (Table 3). We also found that 15% of these women were receiving no medical care at all. Our findings concur with

prior data, which suggest that access to care for low-income minority women would be enhanced if the following issues were addressed:<sup>4-10</sup>

- Accessibility of care
- Respect of patients
- Coordination of services
- Physical environment
- Language barriers
- Transportation issues
- Financial and family concerns

*Funding Opportunities.* During our information-finding phase, we concurrently began seeking funding opportunities. Our major expenses would include staff support as well as ways to help defray costs for patients, as this was a major concern and barrier to care. Although we considered several local service-oriented grants as well as

**Table 2.**  
**Survey Findings: Reported Concerns about Specified Health Issues**

Health Issue	Not concerned (%)	Somewhat concerned (%)	Very concerned (%)	Combined results to show % of women who have any concern
Osteoporosis	13	40	47	87
Cardiovascular Health	17	43	40	83
Nutrition	18	41	41	82
Hormonal Therapy	21	33	46	79
Dental	22	33	45	78
Exercise	33	34	33	67
Incontinence	35	33	32	65
Prolapse	44	36	20	56
Glaucoma & Vision	44	33	23	56
Injury Prevention	45	33	22	55
Sexuality	58	24	18	42
Mental Health	58	17	25	42

**Table 3.**  
**Survey Results:**  
**Reported Barriers to Receiving Health Care**

Item	Women (%) who identified item as barrier
Cost of medications	33
Language	28
Transportation	23
Cost for visit	17
Work schedule	17
Hours facilities are open	11
Parking	10
Fear of medical care	6
Not sure where to go	4
Dislike of Doctors	1

national menopause-focused funding opportunities, we received an unrestricted educational grant from Wyeth Pharmaceuticals. This grant was ideal for our needs as the company was in agreement with our goals and objectives. Both parties agreed that the program should provide a major educational component in an unhindered and non-biased format.

**Table 4.**  
**Practical Recommendations for Starting a Menopause Center**

- ✓ *Have a vision*—Assess the type of menopause service you would like to provide (eg, comprehensive versus consultative)
- ✓ *Assess the components of a successful service*—Take inventory of existing resources and determine needed resources
- ✓ *Survey your population* to determine the issues of concern and barriers to providing an effective practice/receiving optimal care
- ✓ *Assemble a practice/consultation team*
- ✓ *Encourage team members* to obtain certification as menopause clinicians

*Other Menopause Programs.* During the early planning phase of our menopause outreach program, we learned that there was only one other similar clinic in Connecticut, which also was in the planning phase. In researching our options we found at least one commercial menopause program, called “Red Hot Mamas”, that is available for purchase.<sup>11</sup> This program comes complete with prepared educational products and patient-care materials. We opted, however, to develop our own model that was unique to our patients’ needs, and provides both excellent care and educational services.

**The Women’s Life Center**

Our efforts culminated in the opening of the Women’s Life Center in March of 2001. Our clinical arrangement utilizes three exam rooms, a precepting/consultation room, a waiting room, and a secretary/reception desk.

The Center is precepted by two attending physicians, both of whom are board certified in internal medicine and one who has additional board certification in OB/GYN as well as certification as a menopause clinician by The North American Menopause Society. Additionally, our Center has one secretary, one patient care assistant, and the availability of a nurse educator, a nutritionist, an HIV/STD counselor, and social workers. There are residents from OB/GYN, internal medicine and family practice, as well as medical students and nurse practitioners who rotate through this practice.

Although many referrals come from within our larger WAHS, we also receive referrals from other hospital-based primary care clinics, community clinics, and word of mouth.

The patients are seen by at least one person rotating on our service, and each case is reviewed by the team, allowing for discussion and teaching. Additionally, issues related to menopause are presented at the end of office hours, which further enhances education. The program provides an excellent opportunity to discuss menopause symptomatology, urogenital health, osteoporosis, coronary artery disease, breast disease, controversies

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