

Menopause-Focused Medicine: What it Is and How it Works

JoAnn V. Pinkerton MD; Elaine E. Jolly OC, MD, FRCSC;
Marcie K. Richardson, MD; Rebecca S. Kightlinger, DO;
Betsy McClung, MN, RN; and Elizabeth Mandell, MD

Menopause-focused medicine has become a field of specialized practice requiring a high degree of expertise and dedication to excellence in patient care. Menopause clinicians offer a wide array of medical, gynecologic and lifestyle interventions to promote health and treat the symptoms and diseases experienced by women in the menopause transition and beyond.

Menopause is an ideal time to educate patients and intervene to prevent illness. Over the past 15 years, the medical literature has exploded, and the menopause practitioner must keep abreast of an exponentially increasing volume of research data. While establishing a menopause practice limits the scope of one's clinical work, it does not reduce the amount of information to be studied and applied. The practitioner continues to devote his or her many study hours to mastering the gynecologic, medical, endocrine and surgical literature essential to providing care for

midlife women. The North American Menopause Society (NAMS) offers an opportunity for licensed healthcare providers to demonstrate their expertise in this area by passing a competency examination to become certified NAMS Menopause Practitioners.¹

This article begins with the assumption that the clinician who has embarked on a menopause practice has achieved the necessary expertise to care for midlife patients, and has the dedication necessary to develop a center of excellence in midlife health. The practical suggestions and examples of practice

models in this article were drawn from our interviews with practitioners from many different types of menopause-focused practices, which are detailed in the NAMS monograph *Focusing Your Practice on Menopausal Women*.²

Characteristics of Menopause Practices

Menopause practices are devoted to the care of women as they approach menopause and beyond, and include women with spontaneous and medically or surgically induced menopause. Patients seen in a menopause practice include those with severe, persistent or recurrent menopause symptoms in situations in which estrogen is contraindicated or not desired, women with abnormal uterine bleeding, and often in complex medical situations. Menopause practices address issues including urogenital health, prevention and treatment of osteoporosis, prevention of heart disease and recognition of how cancer affects menopausal women. Practices vary by size, type and expertise of the healthcare providers, services provided, patient demographics, and



Menopause practices address issues including urogenital health, prevention and treatment of osteoporosis, prevention of heart disease and recognition of how cancer affects menopausal women.

associated healthcare facilities.

Menopause practices respond to the needs of the community's midlife women, often through a holistic approach. Patients are encouraged to be active participants in their healthcare decisions. "State-of-the-art" diagnostic and treatment procedures are offered by menopause "experts." Most programs emphasize patient counseling and education and provide ongoing educational programs and up-to-date educational materials. In some practices, patients may have the chance to become involved in clinical research trials testing new therapeutic products or diagnostic procedures.

Starting a Menopause Practice

The first step in the process of starting a menopause-focused practice is to undertake a needs assessment. This can be done through surveys or with the help of a marketing consultant. Identifying currently available medical services in the community helps to determine the potential niche that a menopause practice would occupy by taking into account the desires and abilities of the interested providers, as well as available resources. Focus groups of local menopausal women can help determine the perceived needs in the community, and also elicit a response to any plans you have formulated. Physical space needs must be identified, along with start-up costs, continuing expenses and revenue sources.

While a medical practice is inspired by devotion to patient care in one's field of expertise, a medical practice must also be considered a

**While a
medical practice is
inspired by devotion
to patient care in
one's field of
expertise, a medical
practice must also
be considered
a business.**

business. Businesses survive or fail based upon recognized strategies for building a solid foundation, reaching and keeping clients (or in our case, patients), and employing sound business strategies for daily operations and continued growth. Resources and funding are always major concerns. The most significant start-up and ongoing expenses for most practices are the salaries and benefits for the clinicians, staff nurses, educators and office staff. Although most equipment is purchased, larger items, such as ultrasound units, may be leased. Some educational materials may be free; others will need to be purchased in bulk or produced by the office.

In general, reimbursement for procedures and surgery is higher than for office visits, and managed care constraints may affect reimbursement. A few menopause practices with significant reimbursement issues have opted to charge on a fee-for-service basis and not accept insurance, which limits their availability to the general

population. Laboratory and imaging services are needed, although reimbursement rarely comes to the menopause practitioner for these services. The convenience of receiving multiple services in one location may attract patients, but can lead to patients incurring multiple charges.

Marketing a Menopause Practice

Marketing strategies vary depending upon the location of the practice and its objectives, but they should target both patients and referring practitioners with approaches tailored to the specific population. Educational sessions, classes and seminars are an inexpensive way to increase awareness of the practice. In addition, patients often seek clinicians they have seen, heard or met in such settings. Word-of-mouth referrals often come from women who are satisfied patients. Discussion groups offered by a practice may build a cadre of women who become strongly bonded to the practice.³ Advertising can be used to introduce new providers or services, publicize upcoming events and recruit subjects for clinical trials. Sharing menopause expertise through lectures and informative consult notes with interested regional clinicians will help build referrals. Press releases, TV and radio interviews, and newspapers and newsletters can reach a large number of potential patients and increase the visibility of the clinicians in your practice. When determining whether or how to market your practice, consider the practice as a product. What are the unique features of the practice?

(continued on page 15)

Menopause-Focused Medicine: What It Is and How It Works

(continued from page 12)

Would an educational message work better than traditional advertising? Most important, whatever strategy is undertaken, be able to deliver what is promised.

Traits of Successful Practices

Successful practices share common traits. The goal is to meet or exceed expectations of menopausal women with a philosophy of shared decision-making while providing excellent, individualized, up-to-date care. Listening skills and interest in patient-centered care are important qualities both for patient satisfaction and a successful business. While menopause is a normal, natural state, women want acknowledgment that menopausal symptoms can be disruptive to their quality of life. Office visits provide an opportunity to evaluate and modify personal health risks and develop individual prevention strategies. Increased patient knowledge enables informed, shared decision-making between the patient and the provider. Compassion, empathy and respect for confidentiality should be coupled with a professional demeanor. It is particularly helpful, but not always practical, to have a counselor or educator available with sufficient time allowed for further discussion. Many menopause-related issues can be handled through shared medical appointments, where the potential for group dynamics may positively affect patients' learning and understanding of menopausal health issues.⁴

Increased patient knowledge enables informed, shared decision-making between the patient and the provider.

The physical setting of the office should be comfortable, with easy access. Staff should be professional, warm, respectful, interested, knowledgeable and helpful. High-quality educational materials are necessary.

Efficient phone triage is a key to success. Having a receptive, helpful "point person" available at all times decreases patient frustration. Medical records should be easily available and, if shared, privacy must be maintained. Patient satisfaction may be increased by providing easily available ancillary services such as mammography, bone densitometry testing, ultrasound, laboratory services and referral specialists.

It is critical that check-ups and follow-up appointments be scheduled in a timely fashion, particularly for potentially serious conditions. Wait times at the office should be minimized as much as possible. If a provider is running behind schedule, explanations can be offered, with the opportunity to reschedule. Allowing insufficient appointment time while trying to meet productivity standards is a common source of stress for both patients and providers.

Patients appreciate receiving re-

mindings for visits or testing, and having their phone calls returned and their concerns addressed promptly. Timely communication of test results also improves patient satisfaction. Based on patient feedback we have received, a personal discussion of abnormal test results, either over the phone or in the office, is perceived as being of great value. After-hours and emergency access must be provided, although this may be a shared resource with other providers.

How is success defined? Patient-related success can be measured through patient satisfaction surveys and having full schedules. Success increases if the practice addresses individual preferences and expectations through its healthcare delivery, physical setting and provision of counseling and education. A happy staff that works and solves problems as a team creates an atmosphere of trust that is infectious.

Business-related success depends on regular assessment of income, practice growth and size, and referral patterns. Professional and/or personal success is demonstrated through community or regional recognition of high-quality patient care and educational offerings provided by your practice. Research-related success consists of successful funding and completion of trials from industry, foundations or government.

Challenges of Menopause Practices

Meeting the high expectations of an increasingly educated population of women is a menopause clinician's greatest challenge. Patients often read extensively about menopause issues and want to discuss them in

a relaxed and comprehensive manner. This may be difficult to do in a 30-minute initial visit or 15-minute follow-up visit, but must be done if the patient is to have answers that satisfy her need and right to make an informed decision.

Obtaining funds for start-up costs, renovations, equipment and staff salaries may require creativity or partnering with local hospitals or health administrators. Successful revenue generation and billing and reimbursement are crucial to a practice's financial success. Territorial issues and competition with other clinicians may develop, leading to duplication of services or reluctance to refer. This can be avoided by collaborating with clinicians, timely feedback and offering educational consultations.

The logistics of a complex menopause health practice include the need to balance scheduling, telephone triage and reporting of tests results while keeping a busy clinic going. Ongoing training keeps the staff efficient, compassionate and knowledgeable about menopause-related issues.

Practice Models: "Real-World" Examples

Different types of menopause-focused practice models are detailed in the NAMS monograph *Focusing your Practice on Menopausal Women*,² including comprehensive clinics/centers, primary care practices, and dedicated specialty centers tailored to the community and the expertise of the providers. Practice modalities include academic, private practice, educational services only, managed care, consultative service and specialty services on

The logistics of a complex menopause health practice include the need to balance scheduling, telephone triage and reporting of test results while keeping a busy clinic going.

bone, breast, mental health, cardiovascular and sexual health. Several specific practices are described to allow comparisons between different types of practices.

Academic health center: Gynecologist-managed. The Midlife Health Center at the University of Virginia (www.healthsystem.virginia.edu/internet/obgyn/midlife_home.cfm) is within the Department of Obstetrics and Gynecology, and is composed of an interdisciplinary, multidepartmental team with three dedicated gynecologists, one nurse practitioner, an endocrinologist specializing in osteoporosis, a preventive cardiologist and a clinical trial service. The mission of the Midlife Health Center is to prevent illness through education and partnership by meeting the medical, emotional and educational needs of midlife women, to enhance scientific knowledge through clinical research and to provide education for the community and healthcare providers.

Prior to opening the Center, an

eight-member planning team met for 2 years. Meanwhile, the concept of the midlife center was kept "alive" through community and professional educational seminars, while patients were seen in a dedicated "menopause clinic" with an educator present. Issues of power, space and time were handled by key hospital and department administrators on the planning committee. Seed money from the academic medical center and hospital provided nursing and support salaries for 2 years. Cross-fertilization between the hospital and midlife center occurred once the Center was started because knowledgeable, interested, available specialists were in one location. Initial fears that midlife women might be averse to receiving care at a "teaching" hospital were unfounded, as women appreciated the "cutting-edge" knowledge provided by menopause experts.

Over the first 10 years of its operation, the Center's services have changed, expanded or disappeared depending on the needs of the population, the clinical success of the individual practitioners, and the ability of the practitioners to generate sufficient financial income from patient care, clinical research or grants. "Founder's syndrome," in which a project's success is dependent upon the reputation and goals of a single person/provider, was avoided by developing a strong team of dedicated individuals from the outset.

Reimbursement has been dependent on continued patient volume and physician referrals. Every few years, with each administration change, the Center has had to "reprove" itself by showing increasing

patient volume and consistently high patient satisfaction. Efficiency and productivity have been maximized while continuing to provide individualized, comprehensive midlife care. Clinical trials with successful recruitments and retention have provided income used primarily as seed money for additional clinical research. Downstream revenue from referrals, consults and testing is tracked. The reputation of the Center in the community remains high because of patient satisfaction and successful educational seminars and festivals. The Center's comprehensive approach to health care and services were marketed only through community seminars and health fairs. The challenge was to successfully promote the initially low-volume specialty clinics without causing negative marketing because of the oversubscribed menopause services.

Factors critical to the success of the Center include the convenient satellite location, easy parking, and already-established multiple services, including on-site mammography, radiology and laboratory testing. The well-established menopause clinic served as an excellent starting base of patients. Continued positive patient feedback and referrals have kept the Center expanding. Professional updates build team spirit and develop integrated services. Clinical trial success has provided additional recognition and funding. A major factor in the Center's success has been the hand-picked, knowledgeable and compassionate staff and faculty, all of whom work as a team.

Dedicated specialty clinic: Osteoporosis center. The Oregon Osteoporosis Center in Portland, Oregon

**A major factor
in the Center's
success has been
the hand-picked,
knowledgeable and
compassionate
staff and faculty,
all of whom work
as a team.**

(www.oregonosteoporosis.com) is a clinician-owned, multidisciplinary osteoporosis center serving as a resource about osteoporosis and related disorders for physicians, patients and their families throughout the Northwest. Services include a consultative clinic that includes risk assessment, physical and laboratory examination, and treatment of osteoporosis and other metabolic bone disorders.

Services include quantitative measurement of bone density using dual-energy x-ray absorptiometry (DXA), and education for patients, healthcare providers and the community. Clinical research activities allow access to new therapies for patients throughout the region.

Although independent, the practice is located within a large tertiary-care hospital campus and consists of 30 staff members, including bone density technologists, office coordinators, a nurse educator, research physician and study coordinators. The medical director is an endocri-

nologist specializing in metabolic bone diseases and bone density testing. An independent osteoporosis support group is staffed and supported by the Center. A group exercise program and rehabilitation program for patients with osteoporosis has been developed through the hospital's outpatient physical therapy program. At the initial clinic visit, the nurse identifies risk factors and patient expectations, performs the initial assessment (including height measurement) and begins the educational process. The physician reviews the nurse's assessment, conducts the clinical examination, orders diagnostic testing and devises the treatment plan. Following consultation, education, and treatment recommendations, patients return to their referring physicians for ongoing care.

Osteoporosis diagnosis is performed with bone density testing using a quality-controlled DXA scan. Treatment strategies are based on risk assessment, correction of secondary causes of bone loss, and individual indications for pharmacologic and nonpharmacologic therapy.

No marketing strategies have been needed, as educational outreach with providers and consumers is provided through lectures, newsletters and consultation. Financial issues have not been major, as most bone density testing and consultative visits are reimbursed through insurance plans. The key challenge was rapid growth and expansion. Development of a mission statement, which solidified the purpose, vision and values of the Center and its large staff, helped to address this challenge. Expansion

was anticipated and Center staff was involved in planned change to accommodate growth. The computerized records and database have improved patient care and clinical research, as reflected by improved feedback from referring physicians. Clinical research is one of the key components of the Center, and translates into improved patient care. The quality-control program that was put in place to monitor the bone density laboratory assures precise and accurate data and analysis of the data.

Menopause consultation service: Managed care environment. The Harvard Vanguard Menopause Consultation Service (www.harvardvanguard.org/locs/spec2.asp?dpt=Menopause+Consultation+Services) developed out of a 14-site staff model health maintenance organization (HMO) of more than 300,000 members. The HMO was 90% capitated and had an electronic medical record. Menopause care throughout the system was identified as inadequate in surveys of patients and clinicians. Two key individuals, an internist and obstetrician/gynecologist, with the support of the chief of Obstetrics and Gynecology, received a clinical innovation grant to begin the Menopause Consultation Service.

The first goal of the service is clinical: to provide interdisciplinary specialty care to menopause patients with concerns outside the scope of the typical primary care practice. The service is set up for one session per week for each provider. Patients have a 40-minute appointment with each provider. These 40 minutes are spent primarily conducting a patient interview and developing an individ-



**linical
research is one of
the key components
of the Center,
and translates
into improved
patient care.**

ual plan of health management. When possible, the patient is then sent back to the referring clinician with a proposed management plan. Referrals are made as needed to previously identified, interested specialists or resources—either within or outside the Harvard Vanguard network. These include vulvar specialists, behavioral health clinicians, physical therapists and urogynecologists, among others. Additional follow-up is sometimes coordinated through email consultation with the patient's primary care physician.

A half-time nurse initially performed intake interviews, phone triage, patient education and prescription refills for the consult services. A medical assistant now fulfills this highly demanding role. The Menopause Consultation Service is situated in the Fertility and Endocrine Unit of the hospital and their support staff takes phone messages and manages patient visits.

A new goal of the consultation service is to train and integrate nurse practitioners into the practice to handle more straightforward menopause consults and needed telephone and face-to-face follow-ups. The Har-

vard Vanguard Menopause Consultation Service's educational goals include producing an annual conference for prescribing clinicians (often supported with educational grants from the pharmaceutical industry) and developing or providing appropriate patient education materials to the entire HMO practice. The Service also offers menopause-related lectures at all of the HMO's 14 different clinical sites. Faculty participated in developing osteoporosis guidelines for detection, prevention and treatment of osteoporosis, which were distributed to the whole practice. With the rapidly changing hormone therapy (HT) environment, quick responses to new developments in the field for colleagues and practice sites were provided, usually by email with guidance from NAMS.

To date, the Menopause Consultation Service has not been held accountable as a cost center because it is viewed as a service to the group at-large. As Harvard Vanguard is transformed into a multispecialty group in which fewer and fewer of the patients will be capitated, this will undoubtedly change. Consults are generally charged at the L3 or L4 level, but profit does not cover overhead.

In addition to the need for adequate phone triage, the other major challenge for the service has been the number and degree of complexity of email consultations concerning both referred patients seen by the Service and questions from other clinicians related to non-referred patients. To date, these email consults have not been billed.

Patient surveys are uniformly extremely positive. For example, one survey response was, "It was nice/refreshing to meet with a physician

who listened to your concerns and did not dismiss you with a wave of the hand and also to realize there are options for menopausal issues.” The Menopause Consultation Service received the Clinical Innovation Award at the annual Harvard Vanguard Meeting in 2001, just 2½ years after it was started.

Solo private-practice model. In our research for the NAMS monograph *Focusing Your Practice on Menopausal Women*, we evaluated Presque Isle Gynecology in Erie, PA. We found the biggest advantage of a solo private-practice menopause practice to be the freedom with which the founder can tailor the practice to his or her own skills, interests and lifestyle. The office can be individualized and personalized. The practitioner can select staff and train them himself or herself. Office hours, scheduling and the amount of time spent with each patient are determined by the practitioner. Knowing every patient in the practice is very rewarding. For a physician established in an area, marketing can be limited to a newspaper notice and word-of-mouth referrals. The Presque Isle Gynecology practice (which closed in 2004 when Dr. Kightlinger left to join The Midlife Health Center at the University of Virginia) included menopause consultation, outpatient gynecologic care, saline hysterosonography and outpatient surgery.

Some disadvantages are inherent in a solo private practice. Running a business means that the practitioner has responsibility for billing, collections, accounting, paying salaries, taxes, administration of contracts, and dealing with third-party payors, Medicare and Medic-

Because more
income is generated
from outpatient
procedures...solo
practitioners are
under greater
pressure to offer
surgical procedures.

aid. Practitioners must know and apply the Health Insurance Portability and Accountability Act (HIPAA) regulations and state labor laws. Tight control of overhead is essential, as reimbursement for menopause visits remains low and costs escalate yearly.

Because more income is generated from outpatient procedures (as these are reimbursed at a higher level than are preventive health visits), solo practitioners are under greater pressure to offer surgical procedures. Call coverage requires collaboration with other practices, which may have different patient mixes, or different patient problems or expectations. In addition, if only menopause services are offered, other providers must provide inpatient care or major care. There is also the potential for isolation and lack of collegial interaction as menopause specialists are uncommon.

Comprehensive academic center: Nurse-managed (Canada). The Shirley E. Greenberg Women's Health Centre, at the Ottawa Hospital, Riverside Campus in Ottawa, Ontario,

Canada (www.owhc.ca), opened in 2004. This center is a nurse-managed ambulatory healthcare center that focuses on the diagnosis and treatment of women's reproductive health problems, prevention of disease, promotion of health and improvement of quality of life throughout the reproductive, transitional and postmenopausal years. The practice specializes in three areas: mature women's health, cancer screening/oncology and gynecology (benign), all of which employ an interdisciplinary clinical approach.

Data collection supports clinical research, and enables vigorous quality assurance and reviews of outcomes of health management strategies. The goal is to diagnose and treat medical problems, then return patients to their community physicians. A nurse performs the initial assessment, counseling, testing and follow-up. Phone triage is provided by nurses in rotation 5 days per week. Staff members are bilingual in French and English. Patient decision-making tools have been developed and are being updated for postmenopausal HT, breast cancer prevention, osteoporosis and other areas of medicine. The practice provides a comprehensive patient education component through a 3-hour menopause information group session for all new patients prior to being seen at the practice.

Challenges have included developing a strategic plan to obtain approval for the concept of a women's health center. Funding was difficult, but was eventually secured through an influential group of Ottawa women. Initial concerns about getting referrals from family physicians and gynecologists were unfounded.

In 1 year, the Center was oversubscribed, with a 6- to 9-month wait for new-patient appointments.

Lessons Learned

The evaluation of multiple menopause practices that we undertook in the creation of the NAMS monograph² allowed us to make some valuable generalizations that can be shared.

- Listen to and validate the opinions and feelings of patients and staff.
- Remain flexible and be prepared for both personal and professional changes over time.
- Remain focused on your interests and strengths.
- Develop a mission statement and practice goals that are updated periodically; this will help you to reach your long-term goals.
- Scrupulously document all matters related to finances, particularly when a need or cost is challenged. Meticulous documentation of financial matters will reduce or eliminate challenges.
- Don't approach other practices with an "us-versus-them" mindset; colleagues within the practice and the region should be viewed as collaborators, not competitors.
- Monitor stresses on staff and colleagues; failure to do so can lead to "burn out."
- Avoid "founder's syndrome" so the practice is not dependent on one provider's reputation.

Despite the challenges of meeting the high expectations of educated women and ongoing concerns about reimbursement, menopause practitioners interviewed by NAMS report that they enjoy the opportunity to participate in practices focused

Remain flexible and be prepared for both personal and professional changes over time.

on menopausal women. Similar services are being set up, with different challenges, among indigent and minority menopausal women.

Finally, remember to allow residents to participate in menopause practices whenever possible, because residents have little exposure otherwise, and yet will be providing women's health care once they are in practice. ■

JoAnn V. Pinkerton, MD, is Director of Midlife Health and Professor of Obstetrics and Gynecology, University of Virginia Health System, Charlottesville, VA.

Elaine E. Jolly OC, MD, FRCSC, is Medical Director, Shirley E. Greenberg Women's Health Centre, The Ottawa Hospital; and Full Professor, Department of Obstetrics and Gynecology, Faculty of Medicine, University of Ottawa, Ottawa, Ontario, Canada.

Marcie K. Richardson, MD, is Director, Harvard Vanguard Menopause Consultation Service, Boston, MA.

Rebecca S. Kightlinger, DO, is Assistant Professor, Division of Midlife Health, Department of Obstetrics and Gynecology, University of Virginia, Charlottesville, VA.

Betsy McClung, MN, RN, is Associate Director, Oregon Osteoporosis Center, Portland, OR.

Elizabeth Mandell, MD, is Associate Professor, Division of Midlife Health, Department of Obstetrics and Gynecology, University of Virginia Health System, Charlottesville, VA.

Dr. Pinkerton is a consultant for the Council on Hormone Education, DESIGN-WRITE, Merck & Co., and Boehringer Ingelheim, and is involved with the speaker's bu-

reau for Merck & Co. She has received research funding from Wyeth Pharmaceuticals and Solvay Pharmaceuticals. Dr. Richardson is a consultant for Proctor & Gamble. Dr. Mandell is involved with the speaker's bureaus for Wyeth Pharmaceuticals, P&G Aventis and Parke-Davis.

The remaining authors report no potential conflicts related to the content of this article.

Submitted: February 19, 2006. Accepted: May 3, 2006.

Acknowledgments

Additional contributors to The North American Menopause Society (NAMS) monograph, *Focusing Your Practice on Menopausal Women*, include Patricia Smith, MS, C-APNP, University of Wisconsin; Jennifer L. Prouty, MSN, RNC, Mat-tapoisett, MA; and Sheryl A. Kingsberg, PhD, University Hospitals of Cleveland, Cleveland, OH.

References

1. The North American Menopause Society. *Menopause practitioner competency examination 2006 candidate handbook*. Cleveland, OH: The North American Menopause Society, 2006. [Available at www.menopause.org/MPhandbook.pdf] [Accessed July 20, 2006]
2. The North American Menopause Society. *Focusing your practice on menopausal women*. Cleveland, OH: The North American Menopause Society, 2005.
3. The North American Menopause Society. *How to develop a menopause discussion group*. Cleveland, OH: The North American Menopause Society, 2002.
4. Thacker HL. The role of shared medical appointments for midlife women. *Menopause Mgmt* 2006;15:8-16.

Resources

- Anderson RT, Weisman CS, Scholle SH, et al. Evaluation of the quality of care in the clinical care centers of the National Centers of Excellence in Women's Health. *Women's Health Issues* 2002;12:309-26.
- Carlson KJ. Multidisciplinary women's health care and quality of care. *Women's Health Issues* 2000;10:219-25.
- Daigrepoint JP, Mink L, American Medical Association. *Starting a medical practice*. 2nd ed. Chicago, IL: American Medical Association, 2003.
- Goodman RM, Seaver MR, Yoo S, et al. A qualitative evaluation of the National Centers of Excellence in Women's Health Program. *Women's Health Issues* 2002;12:291-308.
- Henry J, Valancy J. *On your own: Starting a medical practice from the ground up*. Leawood, KS: American Academy of Family Physicians, 2001. [Available at www.aafp.org/online/en/home/practicemgt/specialtopics/newpractice.html] [Accessed July 20, 2006]
- Rich D, David J. Menopause clinics: blazing a trail. *OBG Management* 1990;2:34-42.
- The North American Menopause Society. <http://www.menopause.org>. (Phone: 440-442-7550)
- Walowitz PA, Jellen BC, Hanold K, et al. Desperately seeking synergy: the journey to systems integration of women's health services. *Women's Health Issues* 2000;10:161-77.