

HEDIS Measure for the Management of Menopause

Based on presentations by William C. Andrews, MD; and Thomas J. Morrow, MD

Presentation Summary

The Health Plan Employer Data and Information Set (HEDIS) 2000 Management of Menopause measure is designed to evaluate a health plan's provision of counseling to women 47 to 55 years of age (during the past 2 years or ever) on the hormonal and resultant changes that occur during perimenopause and postmenopause. The Management of Menopause measure assesses 3 components of that counseling: exposure to counseling (whether and when it occurred), breadth of counseling (whether information on risks, benefits, and alternatives to hormone replacement therapy were discussed), and personalization of counseling (whether a woman's personal and family medical histories and her own concerns were taken into consideration). The measure does not assess either the decision-making process or the decision made.

In the measure, counseling refers to communication of information to a woman to assist her in making informed decisions about her health. This is not limited to face-to-face encounters but includes all the information a woman receives from her clinician or health plan. Such counseling should include an overview of all changes that can be anticipated during the menopause, with a focus on what a woman can do to manage these changes. The focus may initially be on the short-term symptoms that may bring a woman to the physician's office, such as hot flashes, sleep disturbances, irregular menses, or mood disturbances. Steps that can be taken to prevent or delay diseases associated with long-term estrogen deprivation, such as cardiovascular disease, osteoporosis, colon cancer, and Alzheimer's disease, may be a second focus of discussion. Finally, a discussion of lifestyle modifications should not be overlooked.

© Medical World Communications, Inc.

The National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS) 2000 Management of Menopause survey is the first in the HEDIS Informed Health Care Choices domain.¹ This domain is

designed to assess the patient-clinician partnership, the clinician as a facilitator of a healthy lifestyle, the patient as a decision maker, risk management and disease prevention, patient self-care, and access to health information from the plan and/or the provider.²

Development of the Management of Menopause measure was guided by the US Preventive Services Task Force³ and the American College of Obstetricians and Gynecologists⁴ (ACOG) counseling recommendations for menopausal women, as well as a North American Menopause Society study in 1993 that found only 36% of women reported receiving information about menopause from their physicians.⁵

In field tests of the Management of Menopause measure, the NCQA confirmed that women strongly desire information from their healthcare plans and providers.¹ The survey itself evaluates a health plan's provision of menopause counseling to women ages 47 to 55 years during the past 2 years or ever. It assesses whether counseling occurred and the quality of that counseling, but it does not assess the decision-making process or the decision made (ie, choosing to take hormone replacement therapy [HRT] or alternative treatments for the short-term or long-term effects of menopause).

The Management of Menopause measure consists of 22 questions with 3 subscores—exposure to counseling, breadth of counseling, and personalization of counseling—and a composite score. It must be administered by a qualified independent vendor and can be customized by the health plan.¹

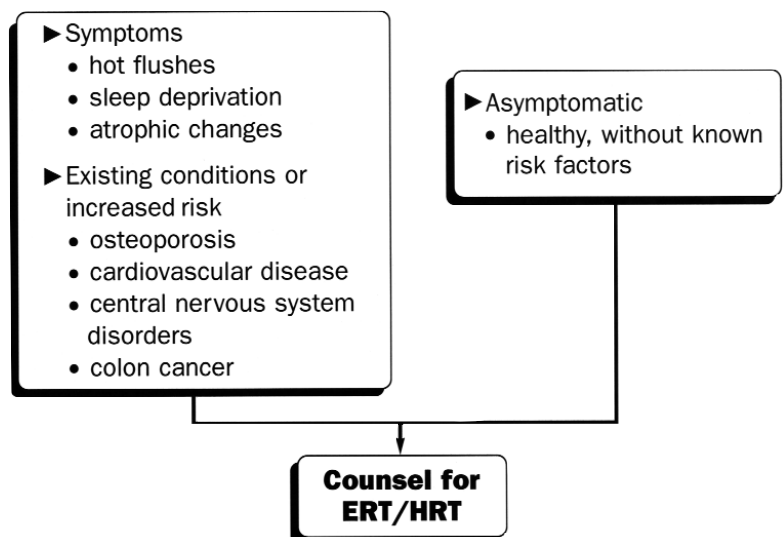
Two sample survey questions for exposure to counseling are, “In the last 2 years, have you talked with a doctor, nurse or other health professional in your health plan about ways to deal with menopause?” and “In the last 2 years, were you given any information about ways to deal with menopause by your doctor's office or your health plan?” (Respondents are asked to answer either “yes” or “no”.) For breadth of counseling, a sample question is, “In the last 2 years, were you informed that hormone replacement therapy may help prevent heart disease?” (“yes,” “no,” “can't recall”). Finally, for personalization of counsel-

ing, respondents are asked, “In the last 2 years, did the information you got about ways to deal with menopause explain how your own and your family's health history might affect what is best for you?” (“yes” or “no”).¹

Counseling methods can differ and may depend on how they are incorporated into individual plans and practices. One of the most effective methods is 1-on-1 discussions with physicians, nurse practitioners, or health educators, supplemented with written materials, videotapes, and discussion groups.⁶

Ideally, counseling on menopause occurs with a focus first on short-term symptoms and treatment and then on long-term prevention or delay of certain disease states (Figure 1). Each woman, by the time she approaches menopause, and certainly by the time she is experiencing menopause, should have been appro-

Figure 1. Menopausal Women and ERT/HRT



Source: Reference 10.

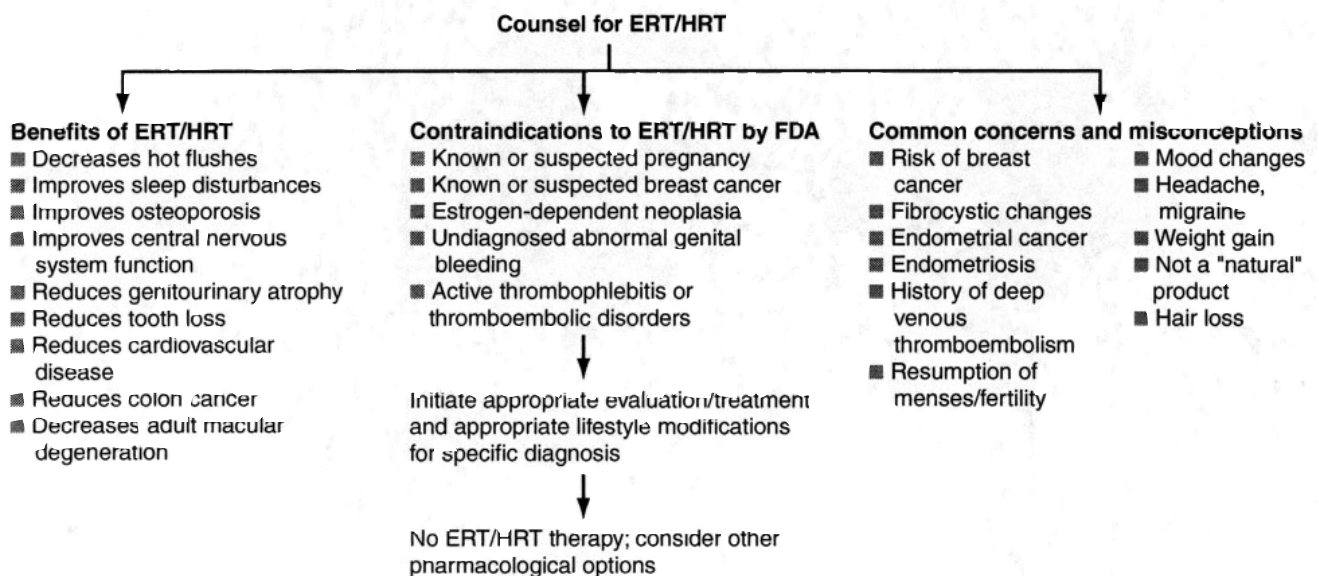
priately counseled. Clinicians have many opportunities to provide this counseling, which should begin when a woman is 45 years old, including during well-woman visits and annual checkups. Such counseling should be thought of as a continuum that mirrors the consequence of estrogen deprivation as a woman ages.⁶

Every woman should be fully informed about the changes in menopause and what she can do to manage these changes. Menopause is defined as the last physiologic period.⁷ Perimenopausal or early symptoms include hot flashes, especially beginning at night; irregular menses (longer or shorter cycles); insomnia; irritability; and mood disturbances. Hot flashes usually increase, occurring during the day as well as at night. Vaginal

thinning from lack of estrogen leads to atrophy and decreased lubrication, causing women to complain of painful intercourse. Cystitis increases in frequency, and stress (urinary) incontinence can occur.⁸ Later in life, diseases that are likely associated with long-term estrogen deprivation include osteoporosis,⁸ cardiovascular disease,⁸ Alzheimer's disease,⁹ and cancer.¹⁰

Hormone replacement therapy is the most comprehensive therapy available for menopause and, for a vast majority of women, an appropriate and excellent solution (Figure 2). Women who do not wish to go on HRT should be provided with information about other options. Lifestyle interventions, which emphasize maintenance of health rather than

Figure 2. Counseling Pathways for ERT/HRT



Source: Adapted from reference 10.

intercession for a disease state, also should not be overlooked. These include normalization of weight; dietary intervention and reduction of saturated fat intake; smoking cessation; regular exercise; and the diagnosis and control of hypertension, diabetes mellitus, alcohol consumption, and dyslipidemia.⁶

A woman can best make an informed—and shared—decision with her physician if counseling is personalized and takes into account her own health history, family history, and values and preferences regarding treatment.

... REFERENCES ...

1. HEDIS®—The Health Plan Employer Data and Information Set. *Volume 3: Specifications for Survey Measures*. Washington, DC: National Committee for Quality Assurance; 2000:131-159.
2. National Committee for Quality Assurance. *Promoting Women's Health: Management of Menopause 2000*. Washington, DC; 2000.
3. US Preventive Services Task Force. *Guide to Clinical Preventive Services*, 2nd ed.

Alexandria, VA: International Medical Publishing; 1996.

4. ACOG Technical Bulletin. Health maintenance for perimenopausal women. Number 210, August 1995.
5. Utian WH, Schiff I. North American Menopause Society-Gallup Survey on women's knowledge, information sources, and attitudes to menopause and hormone replacement therapy. *Menopause* 1994;1:39.
6. Jacobs Institute of Women's Health Expert Panel on Menopause Counseling. *Guidelines for Counseling Women on the Management of Menopause*. Washington, DC: Jacobs Institute of Women's Health; 2000.
7. Woods NF, Mitchell ES. Anticipating menopause: Observations from the Seattle Midlife Women's Health Study. *Menopause* 1999;6:167-173.
8. Speroff L. The menopause: A signal for the future. In: Lobo RA, ed. *Treatment of the Postmenopausal Woman: Basic and Clinical Aspects*. New York, NY: Raven Press; 1994:1-8.
9. Birge SJ. The role of estrogen deficiency in the aging central nervous system. In: Lobo RA, ed. *Treatment of the Postmenopausal Woman: Basic and Clinical Aspects*. New York, NY: Raven Press; 1994:153-157.
10. Hammond CB. *Therapeutic Options for Menopausal Health*. Durham, NC: Duke University School of Medicine and MBK Associates, LLC; 1988. No. 1.

Counseling Information Available

In collaboration with the National Committee for Quality Assurance, the American College of Obstetricians and Gynecologists (ACOG), and the North American Menopause Society, the Jacobs Institute of Women's Health Expert Panel on Menopause Counseling has produced the publication, *Guidelines for Counseling Women on the Management of Menopause*. These guidelines are intended to assist physicians, advanced practice nurses, health educators, and others as well as health plans in providing comprehensive counseling to women about managing menopause. They also specifically address the elements of counseling assessed in the HEDIS 2000 Management of Menopause measure.

The ACOG has published the *Perimenopausal Health Evaluation Form*, which is designed to assist physicians in initiating a discussion with their women patients before they reach menopause. Women record their responses on 2 pages; the physician then records his or her assessment on the next 2 pages. Topics reviewed include menstrual and sexual history, perimenopausal symptoms and self-treatments, family history, personal health status, laboratory tests, physical examination, and education and counseling.