QUALITY STANDARDS

Menopause

Care for Women and Gender-Diverse People

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Ontario Health

Scope of This Quality Standard

This quality standard addresses care for women and gender-diverse people who are experiencing perimenopause or menopause (and postmenopause), including early or surgically induced menopause. The quality standard focuses on the identification, assessment, and management of symptoms at any stage and in all health care settings.

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for patients

Quality standards and their accompanying patient guides are developed by Ontario Health in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca.

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for women and gender-diverse people who are experiencing perimenopause or menopause.

Quality Statement 1: Clinician Knowledge and Skills

Women and gender-diverse people experiencing perimenopause and menopause receive care from a clinician who has the knowledge and skills needed to provide evidence-based menopause care. Clinicians stay current with the knowledge and skills needed to provide evidence-based menopause care.

Quality Statement 2: Identification and Assessment of Perimenopause and Menopause

Starting at age 40, women and gender-diverse people are asked about menopause-associated symptoms to enable the early identification and assessment of perimenopause and menopause.

Quality Statement 3: Evidence-Based Information for People Experiencing Perimenopause or Menopause

Starting at age 40 or earlier, women and gender-diverse people receive evidence-based information about perimenopause and menopause from their clinician.

Quality Statement 4: Management of Vasomotor Symptoms

Women and gender-diverse people experiencing vasomotor symptoms during perimenopause and menopause are offered menopausal hormone therapy as first-line treatment, following an assessment of risks, benefits, contraindications, and individual needs and preferences. People who have contraindications to menopausal hormone therapy or who do not desire it are offered other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments.

Quality Statement 5: Management of Non-vasomotor Symptoms

Women and gender-diverse people experiencing non-vasomotor symptoms during perimenopause and menopause (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition) are offered evidence-based treatment options.

Quality Statement 6: Appropriate Referral to a Clinician With Expertise in Menopause

Women and gender-diverse people experiencing perimenopause or menopause receive assessment and treatment from their primary care clinician and, if clinically indicated, are referred to a clinician with expertise in menopause.

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Notes on Terminology

The terminology used to define the stages of menopause varies across the literature.[1] In this quality standard:

- *Perimenopause* – also called "the menopause transition" – refers to the time before menopause.[1] This stage begins when people experience menopause-associated symptoms and/or persistent variation of 7 or more days in the length of their menstrual cycles (for those who typically experience predictable menstrual cycles).[2] The duration of this stage varies, but it can last up to 10 years for some.[3] People in perimenopause do not need to wait until they are in menopause to receive evidence-based care.
- *Menopause,* in clinical terms, refers to a single day: the date on which 12 months have passed since a person's last menstrual period.[4] However, this term is commonly used to mean both menopause and postmenopause; it is used this way in the quality standard.
- *Postmenopause* refers to the time from menopause until the end of life.[4] Menopause-associated symptoms can continue for several years into postmenopause.[5]

Menopause care refers to care for people at any stage of menopause (perimenopause, menopause, or postmenopause).

Menopausal hormone therapy (instead of *hormone replacement therapy*) is used because ovarian hormones do not need to be routinely "replaced" in people who experience menopause at the average age.[6]

In alignment with Ontario Health's strategic priority to reduce the health inequities experienced by 2SLGBTQIA+ communities, gender-inclusive language is used throughout this quality standard. The term *gender-diverse people* is used to be inclusive of Two-Spirit, trans, nonbinary, and intersex people.

Why This Quality Standard Is Needed

Menopause refers to the health transition from reproductive to nonreproductive status; the clinical definition of menopause is the absence of a menstrual period for 12 consecutive months.[7] People experience menopause at a mean age of 51.4 ± 3.3 years, and about 90% experience natural menopause between the ages of 45 and 55 years.[8,9] On average, perimenopause begins 4 years before a person's last menstrual period,[10] but it can start as early as 10 years before.[3] Premature ovarian insufficiency (i.e., when menopause occurs before age 40 years) or early menopause (i.e., when menopause occurs between the ages of 40 and 44 years) can occur spontaneously, be surgically induced by oophorectomy, or result from chemotherapy and radiation.[9]

Menopause occurs as a result of diminishing reproductive hormones and loss of ovarian follicular function, leading to the end of menstrual cycles.[3] With reduced estrogen levels (i.e., hypoestrogenism),[11] people may experience a variety of symptoms, including vasomotor symptoms (i.e., hot flashes or night sweats[9,12,13]) and genitourinary syndrome of menopause (i.e., vaginal dryness[9,12]; pain or discomfort with sexual intercourse[9]; vulvovaginal discomfort or irritation[9]; or discomfort, pain, or urgency with urination[9,14]). Vasomotor symptoms are the most common, affecting 80% of people who experience menopause and lasting for a median of 7 years after the last menstrual period.[15] Other symptoms can include changes in mood (e.g., depressive symptoms[9] or anxiety[12,13]), musculoskeletal symptoms (e.g., joint and muscle pain[9,12,13]), sexual difficulties,[9,12,13] sleep disturbances,[12,13] changes in weight and/or body fat distribution,[13] and difficulties with concentration or memory.[12,13]

People experiencing perimenopause and menopause should receive high-quality care based on the best available evidence. However, lack of awareness about menopause-associated symptoms is widespread, and people have limited access to clinicians with the knowledge to provide evidence-based menopause care.[4,16] Among Canadians who took part in a survey about menopause in 2022, 46% said that they felt unprepared for this life transition, and 55% felt that they should have learned about it earlier in life.[4] Further, perimenopause is an important window of opportunity for preventative care[17] because it is associated with increased risk of cardiovascular disease and bone loss.[13,18] If people can better understand and prepare for this critical life stage, they may feel more empowered to make informed decisions about their care, optimize lifestyle factors, and improve their overall health.

Clinicians' varying levels of knowledge about and comfort with menopause management have implications for the care people receive. Menopause-associated symptoms are often mistakenly attributed to other conditions, leading to incorrect treatment and delayed care.[19] Some clinicians and trainees have reported discomfort with their level of knowledge about treatment options, avoidance of unfamiliar clinical issues, and feelings of being unprepared to provide menopause care.[20] Over a third (38%) of respondents to the 2022 Canadian menopause survey said that their clinician had undertreated their menopausal symptoms, and only 27% reported that their primary care clinician had initiated a conversation about menopause.[4]

Although recent clinical practice guidelines have recommended menopausal hormone therapy as first-line treatment for vasomotor symptoms (emphasizing individualized assessment of risk factors such as age),[12] clinicians still report hesitation in prescribing it.[21,22] Further, primary care clinicians' lack of knowledge and comfort in providing perimenopause and menopause care leads to unnecessary and inappropriate referrals for specialty care, contributing to long wait times.[23] A Canadian study has estimated that gynecology referrals involve a median wait time of 86 days; 75% of patients waited up to 142 days.[24]

Inadequate care for perimenopause and menopause has substantial social and economic effects. Symptoms can lead to strain on relationships with partners, families, and friends.[25,26] An estimated 10% of people permanently leave their careers as a result of debilitating menopause symptoms.[27] Moreover, Canada loses an estimated $3.5 billion each year due to lost productivity, lost income, and missed days of work linked to menopause-associated symptoms.

All people who experience perimenopause and menopause deserve high-quality care. Little evidence is available detailing inequities in the perimenopause and menopause experience in Ontario, but data from the United States have shown that racialized communities face barriers to accessing care and experience a higher symptom burden. For example, Black people are 60% more likely to experience bothersome and frequent vasomotor symptoms compared to White people,[28] but they are half as likely to start menopausal hormone therapy.[29] Out-of-pocket expenses (e.g., prescription medications, visits to clinicians who are not covered by the Ontario Health Insurance Plan [OHIP]) pose a barrier to receiving care,[30] exacerbating other inequities; financial burden limits access to treatment options for people with fewer resources, disproportionately affecting immigrants and racialized communities.[31] Gender-diverse people also experience inequities in accessing appropriate menopause care (e.g., fear of discrimination, lack of representation in medical forms and protocols, limited research on how gender-affirming hormone therapy interacts with menopausal symptoms),[32] negatively affecting their health outcomes and experiences with the health care system.[33]

A substantial obstacle to understanding the impact of perimenopause and menopause in Ontario is a lack of consistent evidence obtained from systematic data collection and reporting. Standalone (i.e., one-time) surveys are often the only sources of data on people's experiences of perimenopause and menopause, but their applicability is limited, and their sampling often fails to represent the diversity of the Ontario population. Existing Ontario data on menopause-related care describe only physician visits, under-capturing care provided by other clinicians, such as nurse practitioners. As well, the OHIP diagnostic codes used for menopause are poorly recorded and captured (e.g., diagnostic code 627 only broadly captures "Other Disorders of Female Genital Tract: Menopause, post-menopausal bleeding"). Data on the use of menopausal hormone therapy and other treatments for menopause symptoms are also scarce, and even when they are available, they are fragmented or inconsistent, making it challenging to gather and interpret data meaningfully. High-quality, accessible data are needed to enable the tracking of menopause-associated issues and better guide and inform quality improvement efforts.

Given that a large proportion of the Ontario population will inevitably experience perimenopause and menopause, and given the variations in care that people receive, this quality standard represents an important opportunity to identify and address gaps, and to promote high-quality, evidence-based menopause care.

Measurement to Support Improvement

The Menopause Quality Standard Advisory Committee identified 4 overarching indicators to monitor the progress being made toward improving care for people experiencing perimenopause and menopause in Ontario. These indicators are intended for use by those looking to implement the Menopause quality standard, including clinicians working in regional or local roles. Measurement details are available in the technical specifications.

The committee did not identify any provincially measurable indicators because provincial data sources on menopause are limited, as is the ability to identify people experiencing perimenopause or menopause. When data sources or methods are developed that can accurately identify people in perimenopause, the committee will reconsider provincial measures of success for this quality standard.

Indicators That Can Be Measured Using Only Local Data

- Percentage of clinicians who have the knowledge and skills needed to provide evidence-based perimenopause or menopause treatment, including menopausal hormone therapy, non-hormonal medications, and nonpharmacological treatments
- Percentage of women and gender-diverse people aged 40 years or older who receive evidence-based information about perimenopause and menopause from their clinician
- Percentage of women and gender-diverse people experiencing perimenopause or menopause whose primary care clinician refers them to a clinician with expertise in menopause when clinically indicated
- Percentage of women and gender-diverse people who report that their quality of life has improved since receiving menopause care

Quality Statement 1: Clinician Knowledge and Skills

Women and gender-diverse people experiencing perimenopause and menopause receive care from a clinician who has the knowledge and skills needed to provide evidence-based menopause care. Clinicians stay current with the knowledge and skills needed to provide evidence-based menopause care.

Source: Advisory committee consensus

Definitions

Clinician: A regulated professional who provides care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, registered dietitians, and social workers.

Knowledge and skills: To have the necessary knowledge and skills, clinicians should possess an understanding of the following:

- How to identify and assess menopause-associated symptoms during perimenopause and menopause[34]
- Current evidence for treatment options, including menopausal hormone therapy, non-hormonal medications, and nonpharmacological treatments (see quality statements 4 and 5)
- How perimenopause is associated with major physiological changes and presents an important window of opportunity to proactively optimize health, including the importance of taking time to discuss patients' current health status and the long-term implications of menopause[13,34]
- The evidence-based information that should be shared with people experiencing perimenopause or menopause (see quality statement 3)
- How to provide culturally appropriate care for people from racialized groups, and how to address the systemic barriers to high-quality health care that people from racialized groups commonly experience (e.g., racism, discrimination, stigma)[35]
- The influence of intersecting identities and experiences (e.g., trauma, health literacy, culture, race, ethnicity, socioeconomic status, gender identity, and sexual orientation) on menopause experiences and access to care (see Appendix 3, Guiding Principles, Intersectionality)
- When to refer to or seek advice from a clinician with expertise in menopause (see quality statement 6)

Rationale

People experiencing perimenopause or menopause should not have to search for a clinician with the knowledge and skills to provide evidence-based menopause care; all clinicians should be able to provide such care. However, many clinicians have not had an opportunity to obtain these knowledge and skills; medical schools and postgraduate training curriculums do not routinely offer adequate training on this topic. Consequently, some clinicians may have difficulty recognizing menopause-associated symptoms[36]; however, attributing symptoms to other ailments (e.g., depression or a gynecological condition) and failing to recognize the context of perimenopause or menopause can lead to inappropriate treatment. Moreover, some clinicians may hesitate to prescribe menopausal hormone therapy because of outdated research that inaccurately described associated risks – research that has since been reanalyzed and refuted (see quality statement 4).[37]

In a Canadian survey of people who sought medical advice for menopause, 72% of respondents said that the advice they received was not helpful or only somewhat helpful.[4] Not surprisingly, some people feel that they have no choice but to turn to private clinics, where they must pay out of pocket and risk receiving care that is not evidence-based. Others may feel that they have to suffer through their symptoms and endure the consequences for their quality of life and overall health.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Your primary care clinician should have the knowledge and skills to care for you during menopause. This includes identifying the symptoms of menopause, offering treatment options, and helping you stay healthy during this stage of life. They should care for you in a way that takes your culture, values, and beliefs into account. They should also know when to refer you to a clinician with expertise in menopause, or to ask for their advice.

You should not have to look elsewhere for information or care. If you do not have a primary care clinician and usually get care in other settings (such as a walk-in clinic or virtual care), ask the clinician you are seeing about how you can access menopause care.

For Clinicians

Seek out and engage in educational opportunities to ensure that you can identify menopause-associated symptoms, offer evidence-based treatment options, and help people optimize their health and well-being. Participate in training to enable the delivery of culturally appropriate care that recognizes people's intersectional identities.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place for clinicians to access formal and informal training so that they can acquire the knowledge and skills necessary to provide evidence-based menopause care. Ensure the availability of menopause-related training, education, and resources for

clinicians and health care teams, including content on culturally appropriate care so that they can address the intersectional needs of people experiencing perimenopause or menopause.

Embed this quality standard in clinical education programs and curriculums.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of clinicians who have the knowledge and skills needed to provide evidence-based menopause care (potential stratification: primary care clinicians and non–primary care clinicians)
- Percentage of women and gender-diverse people experiencing perimenopause or menopause who report receiving care that is culturally appropriate and free from racism and discrimination

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Identification and Assessment of Perimenopause and Menopause

Starting at age 40, women and gender-diverse people are asked about menopause-associated symptoms to enable the early identification and assessment of perimenopause and menopause.

Sources: Advisory committee consensus | National Institute for Health and Care Excellence, 2024[9]

Definitions

Menopause-associated symptoms: Menopause-associated symptoms, which result from hypoestrogenism (i.e., estrogen deficiency),[11] may begin during perimenopause or menopause, vary from minor to severe, and occur over short or long periods of time.[9] They can include:

- Changes in menstrual cycle[9,13]
- Vasomotor symptoms, such as hot flashes or night sweats[9,12,13]
- Symptoms of genitourinary syndrome of menopause, such as vaginal dryness[9,12]; discomfort with sexual intercourse[9]; vulvovaginal discomfort or irritation[9]; discomfort, pain, or urgency associated with urination[9,14]; or frequent urinary tract infections[38]
- Effects on mood or mental health, such as depressive symptoms[9] or anxiety[12,13]
- Musculoskeletal symptoms, such as joint and muscle pain[9,12,13]
- Sexual difficulties, such as low sexual desire[9,12,13]
- Sleep disturbances[12,13]
- Changes in weight and/or body fat distribution[13]
- Brain fog (e.g., difficulties with concentration, memory, or attention)[12,13]

Depending on their race or ethnicity, people may experience symptoms at different ages[9] and varying intensities.[39] Cultural factors may affect how people experience or describe their symptoms.[39] Awareness of such differences may facilitate the delivery of culturally appropriate care.

Identification and assessment: Identification of perimenopause or menopause is based on the person's menopause-associated symptoms.[9] An example of a tool that can be used to support a conversation about symptoms is the Menopause Quick 6 (MQ6).

For some people, menopause can begin earlier than age 40 years; this is referred to as "premature ovarian insufficiency." A diagnosis of premature ovarian insufficiency is made after considering the

person's clinical and family history, their menopause-associated symptoms (including no or infrequent periods for at least 4 months and taking into account whether they have had a hysterectomy), and whether they have elevated levels of follicle-stimulating hormone (> 25 IU/L). Assessment of follicle-stimulating hormone levels should be repeated after 4 to 6 weeks if the diagnosis is uncertain.[40] If uncertainty remains after repeat assessment, the person may be referred to a clinician with expertise in menopause (see quality statement 6).[9] Note: The management of premature ovarian insufficiency is beyond the scope of this quality standard; detailed information should be sought from other guidance sources.

Laboratory and imaging tests are not indicated for most people, unless their symptoms suggest an alternative diagnosis.[41,42] The following laboratory and imaging tests should *not* be used to identify perimenopause or menopause[9]:

- Anti-Müllerian hormone
- Inhibin A
- Inhibin B
- Antral follicle count
- Ovarian volume
- Estradiol (except in people under age 40 years with suspected premature ovarian insufficiency; people who have had a hysterectomy; or people who use an intrauterine device)
- Follicle-stimulating hormone (except in people under age 40 years with suspected premature ovarian insufficiency; people aged 40 to 45 years who are experiencing menopause-associated symptoms, including changes in menstrual cycle; people who have had a hysterectomy; or people who use an intrauterine device)

It can be difficult to identify perimenopause or menopause in people who are taking hormonal treatments (e.g., treatments for heavy menstrual bleeding[9] or oral contraceptives[42]). If clinically appropriate, it may be suitable for people to stop hormonal treatments temporarily to enable the accurate assessment and identification of perimenopause or menopause.

Rationale

The early identification of menopause-associated symptoms is crucial for timely intervention, support, and treatment. However, both patients and clinicians may be unaware of the full range of potential symptoms, leading them to misattribute symptoms to other causes.[36] People have reported that their clinician dismissed their symptoms, saying that they were too young to be experiencing perimenopause.[20,36] However, delayed identification results in delayed care and missed opportunities to address symptoms. As well, because menopause is associated with increased risk for bone loss and cardiovascular disease,[13,18] delayed identification could also mean missing a critical window of opportunity to optimize overall health.[17]

Given the lack of awareness among the general public about menopause-associated symptoms, people may not realize that they have entered this stage if their clinicians do not start a conversation.

In a Canadian survey, only 27% of respondents indicated that their primary care clinician had initiated a conversation about menopause.[4] Discussions are important because symptom reporting can vary greatly. Language and cultural perceptions can influence how people describe their symptoms, view menopause, determine when to seek medical attention, and advocate for themselves; in turn, these factors can influence how clinicians manage symptoms.[35,43] As well, some people may feel uncomfortable discussing certain symptoms with their clinician, such as changes related to sexual health.[36,38] Clinicians should be proactive about asking about all menopause-related symptoms, regardless of clinical presentation.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are aged 40 years or older, your clinician should ask whether you are having symptoms of menopause. They should describe all of the possible symptoms so that you can talk about what you are experiencing and decide together if you are in perimenopause or menopause. For most people, symptoms are enough to identify perimenopause or menopause. Blood tests or imaging are not needed.

Note: Some people may experience menopause before they turn 40. Speak to your clinician if this is a concern for you.

For Clinicians

Ask people who are aged 40 years or older about menopause-associated symptoms to identify those who are experiencing perimenopause or menopause at the earliest opportunity. Use tools to support conversations about symptoms, such as the Menopause Quick 6 (MQ6).

It is appropriate to initiate a conversation about menopause-associated symptoms even if the person is visiting for an unrelated concern. Support people in learning about all of the possible symptoms of perimenopause or menopause. Treat all people experiencing perimenopause or menopause with respect, dignity, and compassion, and work to establish trust. Listen to them and avoid dismissing or minimizing their symptoms. Be aware that people may use culturally specific language or terminology to describe their symptoms or anatomy; be sure to use the person's preferred terms.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place in all health settings for clinicians to identify and assess people who could be experiencing perimenopause or menopause. Facilitate access to assessment tools or digital enablers that support menopause care.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of women and gender-diverse people aged 40 years or older who report that their clinician has proactively initiated conversations about menopause-associated symptoms

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Evidence-Based Information for People Experiencing Perimenopause or Menopause

Starting at age 40 or earlier, women and gender-diverse people receive evidence-based information about perimenopause and menopause from their clinician.

Sources: Advisory committee consensus | National Institute for Health and Care Excellence, 2024[9]

Definitions

Evidence-based information: This should include the following:

- A description of what menopause is:
  - Menopause is a natural and important health transition that usually takes place in midlife at a mean age of 51 years[8] or on average between the ages of 45 to 55 years[9]
  - Perimenopause is the time preceding menopause; it can last up to 10 years[3]
  - Menopause can happen earlier in life as a result of surgery or medical treatment, an inherited condition, or an unknown cause[9]
  - Premature ovarian sufficiency is the occurrence of menopause before age 40 years; early menopause is the occurrence of menopause between the ages of 40 and 44 years[9]
- The symptoms associated with perimenopause and menopause (see quality statement 2)
- Information about how symptoms can range from minor to severe, can be experienced over a short or long time,[9] and can negatively affect quality of life[44]
- Confirmation that perimenopause and menopause are not medical conditions that require treatment, but that their associated symptoms should be treated proactively if they are affecting a person's quality of life
- Information about how menopause is associated with major physiological changes that have broader health implications, such as:
  - Changes in metabolic health[17] and an accelerated increase in cardiovascular risk factors,[45,46] including elevated blood pressure, cholesterol, and fasting blood glucose levels[13,17]
  - Up to 10% loss of bone mineral density during late perimenopause and the first postmenopausal years[12-14,47]

- The importance of keeping up to date with recommended health screening for breast cancer,[9,34] cervical cancer,[34] and cardiovascular risk factors (i.e., hypertension, cholesterol, diabetes)[11]
- Information about how to optimize bone health and prevent bone loss[9]
- Information about how menopause presents a critical window of opportunity for health promotion and preventative strategies,[13,17] including lifestyle modifications that can optimize health:
  - Managing weight[12,13,48]
  - Managing blood pressure[13,14]
  - Stopping smoking[13,14,45,47,49]
  - Minimizing alcohol intake[34]
  - Engaging in regular physical activity[9,12,13,45,48,49]
  - Engaging in resistance training to maintain muscle mass[9,12,13,49]
  - Maintaining a healthy diet (e.g., a diet high in fibre, protein, and unsaturated fats)[12,13,45,48]
  - Getting sufficient sleep[45]
- Treatment options available to manage symptoms, and the benefits and risks associated with each option (see quality statements 4 and 5)[9]
- Safety concerns associated with compounded bioidentical hormone therapy – an unregulated hormone preparation marketed as an alternative to Health Canada–approved hormone therapies (see quality statement 4)[44,50]
- Information about contraception for people in perimenopause.[9] Because pregnancy can still occur during perimenopause, contraceptive needs should be considered and addressed.[11] The choice of contraceptive method should be individualized, and it should consider the effectiveness, risks, benefits, and side effects of all available methods. Certain contraceptive methods may also alleviate some menopause-associated symptoms.[51] Combined oral contraceptives can be considered to address irregular bleeding[11]
- Fertility-related support and information for people who are likely to experience menopause as a result of medical or surgical treatment[9]

Clinician: A regulated professional who provides care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, registered dietitians, and social workers.

Rationale

Quality of life and overall health improve when people have a better understanding of perimenopause and menopause.[52] However, if people do not receive evidence-based information from their clinician, they must navigate the potential misinformation that is widely available on the Internet and social media,[52] an example being false claims about the safety and effectiveness of compounded bioidentical hormone therapy (see quality statement 4).[53] Sociocultural expectations and influences also shape

how people in perimenopause and menopause seek information; some may view it as a taboo topic that is not to be discussed or as a natural transition that does not require medicalization.[16]

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are aged 40 years or older, your clinician should give you reliable information about perimenopause and menopause. The information should include what menopause is, symptoms you may have, how menopause can affect your heart and bones, how to care for your health during menopause, and treatment options. They should also talk with you about birth control in case you need it, because you can still get pregnant during perimenopause.

For Clinicians

Share evidence-based information with people aged 40 years or older using a proactive, culturally appropriate approach. Engage in discussions to help people understand perimenopause and menopause (including implications for overall health) and address misinformation.

Provide people with the information they need to engage in informed, shared decision-making about treatment options. Support them in making lifestyle modifications to optimize their health. Work with them to set goals and connect them to programs and groups that support health behaviour change. Help people stay up to date with recommended screening for breast cancer and cervical cancer, and monitor for cardiovascular risk factors (i.e., hypertension, high cholesterol, diabetes). Inform people that pregnancy is possible during perimenopause, and ask them about their contraceptive needs.

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place for clinicians to offer people evidence-based information about perimenopause and menopause. Ensure that clinicians have the necessary resources, training, and skills to provide information and education that is culturally appropriate.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of women and gender-diverse people aged 40 years or older who receive evidence-based information about perimenopause and menopause from their clinician
- Percentage of women and gender-diverse people aged 40 years or older who report that the information they received from their clinician about perimenopause and menopause was useful
- Percentage of women and gender-diverse people aged 40 years or older who report that their clinician addressed their questions about perimenopause and menopause

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Management of Vasomotor Symptoms

Women and gender-diverse people experiencing vasomotor symptoms during perimenopause and menopause are offered menopausal hormone therapy as first-line treatment, following an assessment of risks, benefits, contraindications, and individual needs and preferences. People who have contraindications to menopausal hormone therapy or who do not desire it are offered other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments.

Sources: National Institute for Health and Care Excellence, 2024[9] | Obstetrical and Gynaecological Society of Malaysia and the Malaysian Menopause Society, 2022[13] | Society of Obstetricians and Gynaecologists of Canada, 2021[12,14,47,54]

Definitions

Vasomotor symptoms: Hot flashes or night sweats,[9,12] which can begin during perimenopause.[44] Sometimes, hot flashes can be accompanied by anxiety or heart palpitations.[12]

Menopausal hormone therapy: A first-line treatment for vasomotor symptoms that can be offered safely to people who are younger than age 60 years or less than 10 years postmenopause.[12,13,44,54] Clinicians should review recent guidelines and position statements[9,12,13] for guidance (e.g., indications, dosing) and to ensure familiarity with the latest evidence.

Contraceptive needs and bleeding patterns must be considered when choosing an optimal therapy (see quality statement 3). Options for people in perimenopause include low-dose combined hormonal contraceptives; menopausal hormone therapy usually with a cyclical progestogen in people with oligomenorrhea; estrogen in combination with a levonorgestrel-releasing intrauterine system; or progestogen alone.[12,13]

When discussing menopausal hormone therapy, the following should be considered:

- Combined versus estrogen-only:
  - For people with a uterus, offer combined menopausal hormone therapy after discussing the options and identifying the one that best balances benefits and risks[9,13]

  - When offering combined menopausal hormone therapy, the choice of progestogen should favour those least likely to affect markers for cardiovascular disease[54]
  - For people with a uterus, vaginal bleeding is a common side effect of systemic menopausal hormone therapy during the first 3 months of treatment; advise people to seek help if this persists beyond 3 months[9]
  - For people who have had a total hysterectomy, offer estrogen-only menopausal hormone therapy after discussing the options and identifying the one that best balances benefits and risks[9,13,44,47]
  - Explain that taking combined or estrogen-only menopausal hormone therapy is unlikely to affect overall life expectancy[9]
- Transdermal versus oral:
  - Consider transdermal options for people who are at increased risk of venous thromboembolism[9,13] or stroke,[13] or who have comorbidities such as hypertension,[55] obesity,[13,55] dyslipidemia,[13,55] or active gallbladder disease[13]
- Cyclic versus continuous combined:
  - Cyclic menopausal hormone therapy can be used for people in late perimenopause[13] to minimize unscheduled bleeding
  - Continuous combined menopausal hormone therapy is appropriate for people who are 1 year past their final menstrual period[13]
  - Estrogen-only menopausal hormone therapy can be taken every day by people who have had a total hysterectomy[12]
- Dose and duration:
  - Use the lowest effective dose of estrogen[9,12,54]
  - There is no recommended duration or stop time for menopausal hormone therapy; the duration should be individualized based on ongoing symptoms, benefits, and personal risks; this should be re-evaluated periodically[12,13]
  - Discuss the possible duration of treatment at initiation; at every review, discuss the benefits and risks of continuing treatment[9]
  - Explain that symptoms could return when menopausal hormone therapy is stopped; discuss the option of restarting if necessary or desired[9]
  - For people who are stopping menopausal hormone therapy, offer the choice of gradually reducing or immediately stopping treatment (gradually reducing treatment may limit the recurrence of symptoms in the short term, but there is no difference in the longer term)[9]
  - Stop systemic menopausal hormone therapy in people who are diagnosed with breast cancer[9]

Assessment of risks and benefits: The choice of menopausal hormone therapy should be individualized after considering the person's age, symptoms, medical conditions, health risks, and family history, as well as the timing of their final menstrual period.[12]

Contraindications: Contraindications to systemic menopausal hormone therapy include the following:

- Contraindications to estrogen[12,44]:
  - Undiagnosed abnormal vaginal bleeding
  - Active breast cancer, suspected breast cancer, or a personal history of breast cancer
  - Active or suspected estrogen-dependent cancers (i.e., endometrial, ovarian)
  - Coronary heart disease
  - Active venous thromboembolism or a history of venous thromboembolism
  - Active stroke or a history of stroke
  - Known thrombophilia
  - Active liver disease
  - Known or suspected pregnancy
- Contraindications to progestogen[12]:
  - Undiagnosed abnormal vaginal bleeding
  - Active breast cancer or personal history of breast cancer

People with certain contraindications may still be able to use menopausal hormone therapy.[55] For people with a contraindication or a condition that may be affected by menopausal hormone therapy, seek advice on the choice of therapy from a clinician with specialist knowledge of that condition,[9] or refer the person to a clinician with expertise in menopause (see quality statement 6).

Individual needs and preferences: Consider the person's values, preferences, and treatment goals, as well as the affordability of each treatment option.

Evidence-based non-hormonal medications: Non-hormonal medication options include:

- Gabapentin[12,13,47,56]
- Certain selective serotonin reuptake inhibitors and serotonin–norepinephrine reuptake inhibitors[13,47,56] (should not be offered as first-line treatment for vasomotor symptoms alone[9])
- Oxybutynin[47,56]

These treatment options may offer relief from vasomotor symptoms, but they may have their own adverse effects.[12]

Evidence-based nonpharmacological treatments: Nonpharmacological treatment options include:

- Cognitive behavioural therapy,[9,13,47,56] which can include face-to-face or remote sessions, individual or group sessions, and self-help options, depending on the person's preferences and needs[9]
- Clinical hypnosis[12,13,56]

Rationale

Vasomotor symptoms are the most common menopause-associated symptom, affecting 80% of people and lasting for a median of 7 years after the last menstrual period.[15] These symptoms have negative effects on quality of life,[12] and their presence has been independently linked with an increase in cardiovascular risk factors.[44,50] Early-onset and persistently frequent vasomotor symptoms have been associated with more adverse health and psychosocial issues than less frequent symptoms.[57]

Current clinical practice guidelines recommend the use of menopausal hormone therapy as first-line treatment for vasomotor symptoms for people in perimenopause or menopause.[12,13,44,54] Evidence also demonstrates additional benefits, including the prevention of bone loss[44] and postmenopausal osteoporosis,[44] reductions in fracture risk in healthy people postmenopause,[9,44,58,59] and relief of symptoms of genitourinary syndrome of menopause (see quality statement 5).[44] Still, clinicians report hesitation in prescribing it.[21,22] This hesitation has been attributed largely to the legacy of the Women's Health Initiative, an influential randomized study launched in 1998 that aimed to evaluate the effects of menopausal hormone therapy. Previously published results inaccurately described the risks associated with menopausal hormone therapy. These findings have since been reanalyzed and refuted, but uncertainty around its use persists.[37] According to data from the Canadian Longitudinal Study on Aging (ICES, 2024/25), 10.6% of women in Ontario between the ages of 45 and 60 years who had experienced menopause reported current use of menopausal hormone therapy between 2014 and 2018.

If people experiencing vasomotor symptoms have contraindications to menopausal hormone therapy or prefer not to take it, non-hormonal medications and nonpharmacological treatment options are available. Fezolinetant, a neurokinin B antagonist, is a new non-hormonal pharmacological option for the treatment of vasomotor symptoms[56,60] that was approved by Health Canada in 2024.

Note: Compounded bioidentical hormone therapy is an unregulated hormone preparation that has been marketed as an alternative to Health Canada–approved hormone therapies. Several safety concerns are related to its use, including minimal government regulation and monitoring, overdosing and underdosing, the presence of impurities and lack of sterility, the lack of scientific efficacy and safety data, and the lack of a label outlining risks.[44,50] It is also typically associated with out-of-pocket costs. Compounded bioidentical hormone therapy is not approved by Health Canada, is not considered standard of care, and should not be offered in place of pharmaceutical-grade menopausal hormone therapy.[44,61,62] Instead, people should be offered Health Canada–approved hormone preparations, which are proven to be safe and may be more cost-effective or covered by public or private health insurance plans.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

If you are having hot flashes or night sweats and you would like to treat them, your clinician should offer you menopausal hormone therapy. If you cannot take it or do not want to take it, they should offer you other options. Your clinician should assess your overall health so that you can work together to choose the treatment option that is best for you.

Your clinician may ask you how bothersome your symptoms are. Whether or not a symptom is bothersome is entirely up to you. If your hot flashes or night sweats affect your quality of life, your clinician should offer you treatment. If you try a medication and you are not feeling well on it or your symptoms do not improve, talk with your clinician to see if you can try something else.

The cost of medications or other treatments should not stop you from getting the care you need. Your clinician can tell you about free or low-cost options.

For Clinicians

Talk with people about their symptoms and share evidence-based information about menopausal hormone therapy, including its safety and effectiveness. Explain the safety concerns related to compounded bioidentical hormone therapy.

Reassure people that treatment decisions should be informed by the symptoms they are experiencing and how bothersome those symptoms are. If the person tries a medication and does not feel well on it or does not notice improvement, offer another option.

Discuss the affordability of each treatment option and support people in navigating ways to reduce costs or find coverage (e.g., publicly funded programs, generic medications, low-cost alternatives, or community resources).

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place – and that educational opportunities are available – so that clinicians can appropriately offer menopausal hormone therapy or evidence-based non-hormonal or nonpharmacological treatment options to people experiencing vasomotor symptoms associated with perimenopause or menopause.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of women and gender-diverse people experiencing vasomotor symptoms whose clinician offers them menopausal hormone therapy as first-line treatment when it is safe and appropriate
- Percentage of women and gender-diverse people experiencing vasomotor symptoms who have contraindications to menopausal hormone therapy or do not desire it and whose clinician offers them other evidence-based treatment options, including non-hormonal medications and nonpharmacological treatments
- Percentage of women and gender-diverse people experiencing perimenopause or menopause who feel involved in discussions with their clinician about their medication options, including risks, benefits, contraindications, and individual needs and preferences

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Management of Non-vasomotor Symptoms

Women and gender-diverse people experiencing non-vasomotor symptoms during perimenopause and menopause (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition) are offered evidence-based treatment options.

Sources: National Institute for Health and Care Excellence, 2024[9] | Obstetrical and Gynaecological Society of Malaysia and the Malaysian Menopause Society, 2022[13] | Society of Obstetricians and Gynaecologists of Canada, 2021[14,47,48,63]

Definitions

Non-vasomotor symptoms: People experiencing perimenopause or menopause may experience symptoms other than vasomotor symptoms, including:

- Changes in menstrual cycle[9,13]
- Symptoms of genitourinary syndrome of menopause, such as vaginal dryness[9,12]; discomfort with sexual intercourse[9]; vulvovaginal discomfort or irritation[9]; discomfort, pain, or urgency associated with urination[9,14]; or frequent urinary tract infections[38]
- Effects on mood, such as depressive symptoms[9] or anxiety[12,13]
- Musculoskeletal symptoms, such as joint and muscle pain[9,12,13]
- Sexual difficulties, such as low sexual desire[9,12,13]
- Sleep disturbances[12,13]
- Changes in weight and/or body fat distribution[13]
- Difficulties with concentration or memory (often called “brain fog”)[12,13]

Evidence-based treatment options: For symptoms of genitourinary syndrome of menopause:

- Local low-dose vaginal estrogen (in the form of a cream, tablet, insert, or ring) is a safe and effective option that should be offered to people experiencing symptoms of genitourinary syndrome of menopause,[9,64] including those who are already using systemic menopausal hormone therapy[9]

  - Vaginal estrogen is absorbed locally[9] and works to improve blood supply to the urogenital tissues[14]; because only a minimal amount is absorbed into the bloodstream, it is unlikely to have a significant effect throughout the rest of the body[9]
  - Serious adverse events from the use of vaginal estrogen are very rare[9,13]
  - Symptoms often return when vaginal estrogen is stopped, but treatment can be restarted if necessary[9,38]
  - Vaginal estrogen can be used alone or in combination with non-hormonal lubricants and moisturizers[9,38]
- Other hormonal treatment options include dehydroepiandrosterone ovules (DHEA, also known as prasterone) and ospemifene[9,14,64]
  - DHEA is an intravaginal treatment that can be considered as an alternative to vaginal estrogen if non-hormonal lubricants or moisturizers are ineffective or not tolerated[9,65]
  - Ospemifene, a selective estrogen receptor modulator, is an oral treatment that can be considered as an alternative to vaginal therapies (e.g., vaginal estrogen, DHEA, or non-hormonal vaginal lubricants and moisturizers) if vaginal options are impractical (e.g., due to severe pain or disability) or not desired[9,66]
- Non-hormonal options available over the counter, including vaginal lubricants and moisturizers, can be offered to people who cannot use or prefer not to use hormonal options[9]
  - Lubricants can be used as needed to help provide short-term relief of discomfort during sexual intercourse by reducing friction[14,64]
  - Moisturizers require regular application and can provide more continuous relief than lubricants,[3] independent of the time of sexual intercourse[64]

For symptoms related to sexual health, such as low sexual desire:

- To facilitate appropriate treatment, the person's symptoms should be identified as being related to desire, arousal, pain, or orgasm[63]
- Testosterone supplementation can be offered to people with low sexual desire associated with menopause[63] if menopausal hormone therapy alone is not effective[9]
- Other options for managing low sexual desire in postmenopausal people include managing pain, addressing biopsychological factors, and counselling[63]

For symptoms related to mental health, such as depressive symptoms or anxiety:

- For people in perimenopause experiencing depressive symptoms that do not meet the criteria for a diagnosis of depression, treatment options include menopausal hormone therapy[9,48] and/or cognitive behavioural therapy,[9] which can include face-to-face or remote sessions, individual or group sessions, and self-help options, depending on the person's preferences and needs[9]

- For people with diagnosed depression, refer to the Ontario Health quality standard *Major Depression: Care for Adults and Adolescents*[67]
- For people with an anxiety disorder, refer to the Ontario Health quality standard *Anxiety Disorders: Care in All Settings*[68]

For symptoms related to sleep:

- An initial approach should include education about sleep hygiene, ruling out primary sleep disorders (e.g., obstructive sleep apnea), and addressing vasomotor symptoms.[48] For people with insomnia disorder, refer to the Ontario Health quality standard *Insomnia Disorder: Care for Adults*[69]
- Menopausal hormone therapy may improve sleep in people who have vasomotor symptoms because these symptoms are an important contributor to sleep disruption[48]
- Other options that have shown benefit for sleep include cognitive behavioural therapy for insomnia[9,48] and aerobic exercise[48]

For symptoms related to cognition:

- Lifestyle modifications can be encouraged to reduce the risk of cognitive decline, such as increasing aerobic exercise, including more vegetables in the diet, and limiting the potential influence of hypertension, atherosclerotic disease, and diabetes[48]
- Menopausal hormone therapy has not been shown to significantly improve measures of cognitive function over several years of use[48]

Rationale

Non-vasomotor symptoms experienced during perimenopause or menopause can be distressing and affect quality of life.[70] In particular, symptoms associated with genitourinary syndrome of menopause can have substantial adverse effects on a person's daily living, quality of life, and sexual health.[38,71,72] Unlike other menopause-associated symptoms (which usually improve with time), symptoms of genitourinary syndrome of menopause generally persist and worsen without effective treatment[38,73] because of functional and structural changes to urogenital tissues that can be difficult to reverse.[14] Racial and ethnic disparities exist in the experience of genitourinary syndrome of menopause: in the US Study of Women's Health Across the Nation, Black people in menopause reported vaginal dryness more often than White people.[74]

Awareness of genitourinary syndrome of menopause and available treatment options is low, and this topic is not frequently discussed during clinician visits.[73] For this reason, clinicians should share information about the progressive impact of estrogen deficiency,[14] proactively inquire about symptoms in all people experiencing perimenopause and menopause,[38] and offer evidence-based treatment options. In addition to the treatment options for genitourinary symptoms listed above, pelvic floor physiotherapy may be beneficial for people experiencing pain during sexual intercourse.[14]

Other non-vasomotor symptoms during perimenopause or menopause should be addressed to optimize quality of life. Perimenopause is a particularly vulnerable period for the development of depressive symptoms and major depressive episodes, even in people without a history of depression. Depressive symptoms are highly prevalent but often under-recognized and undertreated.[48] It is important to recognize these symptoms in the context of perimenopause or menopause so that they can be treated appropriately.[36] Symptoms related to sleep – including poor sleep quality – are also common among people in perimenopause and menopause. Depression and sleep disturbances are both linked to increased risk of cardiovascular disease.[46] Cognitive symptoms, such as worsening memory or slower cognitive speed (sometimes described as "brain fog"), are an important concern for many people.[48]

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Hot flashes are not the only symptom of perimenopause and menopause. Other symptoms include vaginal dryness, mood changes, joint and muscle pain, pain during sex, trouble sleeping, weight changes, and brain fog.

Your clinician should offer a safe and comfortable environment for you to talk about your symptoms. They should talk with you about treatment options so that you can work together to choose what is best for you.

For Clinicians

Ask people about their non-vasomotor symptoms and offer evidence-based treatment options that align with their needs and preferences. Offer a safe environment for discussion and help normalize conversations about their experiences: symptoms related to genitourinary syndrome of menopause or sexual health can be especially uncomfortable for people to talk about.

Discuss the affordability of each treatment option and support people in navigating ways to reduce costs or find coverage (e.g., publicly funded programs, generic medications, low-cost alternatives, or community resources).

For Organizations and Health Services Planners

Ensure that systems, processes, and resources are in place – and that educational opportunities are available – so that clinicians can appropriately offer evidence-based treatment options to people experiencing non-vasomotor symptoms associated with perimenopause or menopause.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of women and gender-diverse people experiencing perimenopause or menopause who report that their clinicians always or often involves them in decisions about evidence-based treatment options for non-vasomotor symptoms (including those related to genitourinary syndrome of menopause, sexual health, mental health, sleep, and cognition)
- Percentage of women and gender-diverse people experiencing genitourinary syndrome of menopause whose clinician offers them evidence-based treatment options

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 6: Appropriate Referral to a Clinician With Expertise in Menopause

Women and gender-diverse people experiencing perimenopause or menopause receive assessment and treatment from their primary care clinician and, if clinically indicated, are referred to a clinician with expertise in menopause.

Source: National Institute for Health and Care Excellence, 2024[9]

Definitions

Primary care clinician: A family physician (also called a primary care physician) or nurse practitioner.

Clinically indicated: Before referral, people should receive assessment (see quality statement 2) and treatment (see quality statements 4 and 5) from their primary care clinician, so that they do not experience delays in starting care. Clinical indications for referral to a clinician with expertise in menopause include the following[9]:

- No improvement in menopause-associated symptoms with treatment, or experiencing continued side effects
- Contraindications to menopausal hormone therapy (see quality statement 4)
- Uncertainty about a diagnosis of premature ovarian insufficiency
- Menopause-associated symptoms in a person who has taken gender-affirming hormone therapy

Clinician with expertise in menopause: A clinician who has the specialist knowledge, skills, and training to provide care to people with complex menopause-related needs or risk factors that may affect decision-making, such as complex medical conditions that may affect the use of certain treatments for menopause-associated symptoms.[9]

Rationale

For most people, evidence-based menopause care should be provided by their primary care clinician. However, some may require care from a clinician with expertise in menopause, depending on their response to treatment or health history. For example, for people who have taken gender-affirming hormone therapy, it is unknown whether the previous use of hormones could influence the choice of menopausal hormone therapy or the risks associated with treatment. This population should have an opportunity to engage in shared decision-making with a clinician who has expertise in menopause.[9]

Given that there are often long wait times to access care from a clinician with expertise in menopause, people should be referred only when necessary and appropriate. In some cases, a telephone or secure electronic consultation between clinicians may be sufficient for decision-making and may also help build capacity among primary care clinicians. This may be particularly helpful for clinicians located in rural, remote, or underserved regions.

What This Quality Statement Means

For People Experiencing Perimenopause or Menopause

Your primary care clinician may need to ask for advice or refer you to another clinician who specializes in menopause. This is usually an obstetrician-gynecologist, but it might also be an endocrinologist or another primary care clinician.

Before they refer you, your primary care clinician should assess you thoroughly and offer you treatment so that you do not have to wait to manage your symptoms. If you would like to ask for a referral, talk with your primary care clinician.

For Clinicians

Assess people experiencing perimenopause or menopause and offer treatment before considering referral to a clinician with expertise in menopause. Refer when it is clinically indicated, when you do not yet possess the knowledge and skills to provide appropriate care, or when your patient requests a referral. Provide a detailed referral, including the person's symptoms, treatment, and the clinical indication for referral. Consider the person's needs and preferences (e.g., a female clinician or a clinician who speaks a certain language).

You may also choose to seek advice from a clinician who has expertise in menopause.

For Organizations and Health Services Planners

Ensure the availability of clinicians with expertise in menopause. Ensure that systems, processes, and resources are in place for primary care clinicians to seek advice. Ensure access to virtual platforms so that consultations can be delivered virtually via telemedicine or other remote technologies.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of women and gender-diverse people experiencing perimenopause or menopause who receive assessment and treatment from their primary care clinician before being referred to a clinician with expertise in menopause

- Percentage of women and gender-diverse people experiencing perimenopause or menopause whose primary care clinician refers them to a clinician with expertise in menopause when clinically indicated
- Wait time between referral to a clinician with expertise in menopause and first consultation

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For People Experiencing Perimenopause or Menopause

This quality standard consists of quality statements. These describe what high-quality care looks like for people experiencing perimenopause or menopause.

Within each quality statement, we have included information on what these statements mean for you as a patient.

In addition, you may want to download this accompanying patient guide on menopause to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for people experiencing perimenopause or menopause. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on menopause, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement processes
- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of health care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person experiencing perimenopause or menopause. Other terms commonly used to describe this role include "caregiver," "informal caregiver," "family caregiver," "carer," and "primary caregiver."
Clinician	A regulated professional who provides care to patients or clients. Examples are nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, registered dietitians, and social workers.
Culturally appropriate care	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person's preferred language; adapts culture-specific advice; and incorporates the person's wishes to involve family or community members.[75]
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, child life specialists, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.
Menopausal hormone therapy	A prescription medication containing hormones that is recommended as first-line treatment for vasomotor symptoms in people experiencing perimenopause or menopause.[12,44]
Menopause	The day on which 12 months have passed since a person's last menstrual period.[4] This term is commonly used to refer to both menopause and postmenopause, and we have used it this way in the quality standard.
Perimenopause	The time before menopause (also called "the menopause transition"[1]), which begins when people experience menopause-associated symptoms and/or persistent variation of 7 or more days in the length of their menstrual cycles (for those who typically experience predictable menstrual cycles).[2] The duration of this stage varies, but it can last up to 10 years for some.[3]
Postmenopause	The time from menopause until the end of life.[4] Menopause-associated symptoms can continue for several years into postmenopause.[5]
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician who the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request laboratory testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created and should be implemented according to the *Patient, Family and Caregiver Declaration of Values for Ontario*. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

A quality health system is one that provides good access, experience, and outcomes for all people in Ontario, no matter where they live, what they have, or who they are.

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally relevant care or acknowledge traditional Indigenous beliefs, practices, and models of care.

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 27 designated areas and at government head offices.[76]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People with a mental illness or addiction often live under very stressful social and economic conditions that worsen their mental health,[77] including social stigma, discrimination, and a lack of access to education, employment, income, and housing.[78]

Identifying and Addressing Racism and Discrimination

Many people in Ontario experience racism and discrimination in their interactions with the health care system, negatively affecting the quality, safety, and effectiveness of the health care they receive.[79,80] Racism refers to systemic discrimination that is deeply embedded in organizational cultures, policies, directives, practices, or procedures; it causes harm by excluding, displacing, marginalizing, and perpetuating unfair barriers and treatment towards racialized populations.[81] These populations often face profound disparities in accessing and receiving timely, anti-racist, anti-oppressive, culturally appropriate, and culturally responsive health care.[79,82,83] To advance health equity and achieve better outcomes for all, the harmful effects and impacts of racism and discrimination must be explicitly identified and addressed.[81] Adopting an anti-racist and anti-oppressive approach recognizes the existence of racism and people's intersectional identities; it then actively seeks to identify, reduce, and remove racially inequitable outcomes, power imbalances, and the structures that sustain those inequities.[81]

Intersectionality

Intersectionality refers to people's differing experiences with discrimination and injustice based on social categorizations such as race or ethnicity, class, age, or gender, and the interaction of these experiences with compounding power structures (e.g., the media, the education system, and the health care system). Such interconnected categorizations create overlapping and interdependent systems of discrimination or disadvantage.[84-86] For example, the stigma experienced by people experiencing perimenopause or menopause can vary depending on clinical and demographic characteristics such as racial or ethnic background and gender identity, as well as on other characteristics such as language(s) spoken or perceived socioeconomic status. Understanding how the various aspects of people's identities intersect can provide insights into the complex causes of health inequities and how different people experience stigma and discrimination.[33,87]

Self-Management

People experiencing perimenopause or menopause and their families, care partners, and personal supports should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.[88] Further, people should be empowered to make informed choices about the services that best meet their needs.[89] People experiencing perimenopause or menopause should engage with their clinicians in informed, shared decision-

making about their treatment options. Each person is unique and has the right to determine their own path toward health and well-being.[88]

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[90,91] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns, and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[92,93] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[91-93]

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About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an *Equity, Inclusion, Diversity and Anti-Racism Framework*, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

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