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# Perceived Barriers and Recommendations Concerning Hormone Replacement Therapy Counseling Among Primary Care Providers

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**Abstract**

***Objective:*** To increase our understanding of the factors that impede or promote counseling about hormone replacement therapy, we asked clinicians to provide information concerning barriers and strategies to promote counseling.

***Design:*** We asked clinicians to consider two different scenarios: (1) what they do in their current practice and (2) what they would do if their health care systems implemented the United States Preventive Services Task Force recommendation regarding hormone replacement therapy counseling. A total of 49 of 50 invited clinicians participated in one of six focus group interviews (three women's groups and three men's groups). Our analysis consisted of four steps: (1) identifying segments and classifying them into themes, (2) categorizing themes into topic areas, (3) establishing a final consensus of themes and topics, and (4) ascertaining similarities and contrasts among groups. Transcripts of sessions were analyzed across groups for themes using a text-based analysis system. Conceptualization of themes was derived using a system model of preventive care. Interrater agreement before consensus was good: Kappa (κ) ranged from 0.70 to 1.00.

***Results:*** For current practice, identified barriers included lack of information about risks and benefits, unique challenges of counseling, and lack of resources to conduct counseling. The major strategies suggested were to develop and distribute patient education materials. Discussions about barriers to implementing the United States Task Force recommendation focused on lack of information and resources.

***Conclusions:*** Suggested strategies were multiple, involving individual-, relationship-, and system-level interventions. We expect the strategies identified to be supportive of future efforts to promote counseling for hormone replacement therapy. (*Menopause* 1999;6:161–166. © 1999, The North American Menopause Society.)

***Key Words:*** Providers – Physicians – Barriers – Strategies – Hormone replacement therapy.

The 1996 report of the United States Preventive Services Task Force recommends "counseling all perimenopausal and postmenopausal women about the potential benefits and risks of hormone prophylaxis..."[1] The Task Force's recommendation, coupled with the increased public attention, is exerting considerable pressure on researchers and clinicians to improve hormone replacement therapy (HRT) counseling. One example is the inclusion of HRT counseling as part of the Health Plan Employer Data and Information Set 3.0 test set of performance measures.[2] Another likely consequence is the development of new clinical guidelines for counseling. As a result, clinicians are increasingly likely to be confronted with issues concerning HRT counseling.

Despite the increasing research in HRT, little information has been published about clinicians' practice and beliefs regarding HRT use.[3–9] Moreover, few studies have examined the barriers and facilitators to providing HRT

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counseling rather than HRT use. We have previously attempted to determine health care providers' preferences for different methods of informing women about HRT.[10] Using a survey of 366 healthcare providers at a health maintenance organization, we found that more than 79% of the respondents reported that they would use literature, videos, classes, nonphysician counseling, follow-up appointments, and telephone follow-up, if available. Although these results signify that clinicians perceive a need for supportive interventions, there is no indication of what strategy or set of strategies will best promote HRT counseling. An increased understanding of barriers that impede and strategies that support counseling is essential to developing effective clinical support interventions.

The present study was conducted to provide an in-depth exploration of the factors that impede or promote HRT counseling in ambulatory care. We first examined clinicians' views about the barriers that may impede counseling and strategies to support counseling in their current practice. We then explored clinicians' opinions about barriers to and suggestions for implementing the United States Preventive Services Task Force (hereafter referred to as United States Task Force) recommendation in their practice.

Because of the questions about the influence of gender on the delivery of preventive care,[11] we compared the identified barriers and suggestions for women and for men provider groups.

## METHODS

### Participants and procedures

The study was conducted at Group Health Cooperative of Puget Sound, a 450,000 member staff model health maintenance organization in the northwest United States. We identified potential participants from an administrative database of all healthcare providers at Group Health Cooperative. Selection criteria included an active practice (i.e., at least one patient "well visit" during May to June of 1996) in internal medicine, family practice, or obstetrics/gynecology within the greater metropolitan area of Seattle. We had a pool of 190 physicians who were potentially eligible. Our goal was to recruit a total of 50 participants (25 women and 25 men), enough for six groups.

In response to a variety of recruitment strategies, including written and oral invitations, 50 physicians indicated an interest in participating in the focus group interviews. Physicians were offered $100 for participating. Based on their responses, dates were established for the focus groups. Reminder letters were sent before the event. A total of 49 of the 50 invited physicians participated in one of six focus groups (24 women and 25 men).

Focus group interviews were conducted during the fall of 1996 at an independent marketing research firm. Two trained facilitators with experience in qualitative data collection served as focus group moderators. A moderator of the same sex as the group facilitated the session, while the second moderator served as the recorder. Each session was videotaped and audiotaped for transcription and analysis. To guide the discussion, a set of questions related to HRT counseling was designed and pretested. The first question invited participants to describe their experiences with HRT counseling, including their perceptions about available resources, barriers, and suggested strategies to improve counseling. The second question reviewed the United States Task Force recommendation on counseling about HRT and asked participants what it would mean to their practice if the recommendation were implemented at Group Health Cooperative. This included exploring their perceptions about barriers to and suggested strategies for implementing the counseling recommendation. The role of the moderator was to introduce questions, seek clarification from participants, encourage participation, and introduce areas not yet discussed by the group.[12] Procedures were approved by the Institutional Review Boards of Group Health Cooperative and the Centers for Disease Control and Prevention.

## ANALYSIS

Our analysis consisted of four steps: (1) identifying segments and classifying them into themes, (2) categorizing themes into specific topic areas, (3) establishing a final consensus of themes and topics, and (4) ascertaining similarities and contrasts among groups. Conceptualization of themes was derived from the work of Walsh and McPhee,[13] describing a systems model in the delivery of preventive care. Their model underscores the importance of providers, patients, and health care systems. These three dimensions served as the theoretical framework for abstracting segments: (1) individual-level factors (patients or providers), (2) relational-level factors (patient-provider interactions), and (3) organizational-level factors (system) (Fig. 1).

Audiotapes from each focus group were transcribed verbatim by a professional transcribing service. Transcripts averaged approximately 29 pages, which is typical for focus groups.[14] Each transcript was analyzed using Ethnograph v4.0, a text-based analysis program.[15] Two coders (a behavioral scientist, L.A., and a physician/epidemiologist, L.C.) identified and classified segments into themes. Coders initially worked together but subsequently

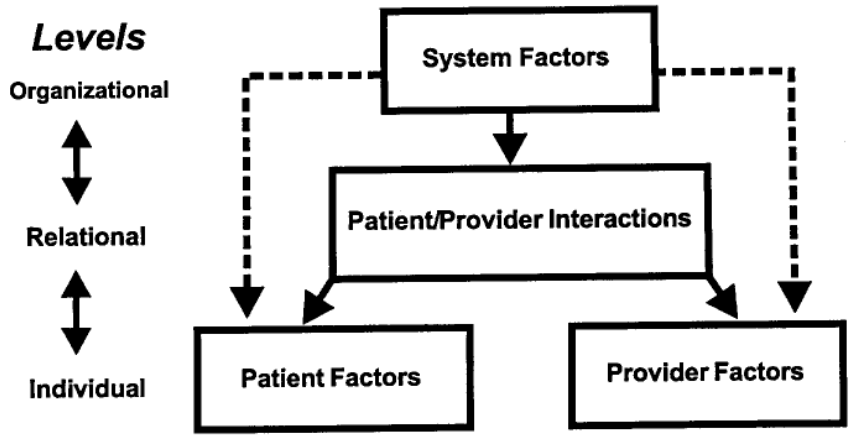


**FIG. 1.** Walsh and McPhee system model of care: conceptualization of themes. (Based on the work of Walsh, JME and McPhee, SH. A systems model of clinical preventive care: an analysis of factors influencing patient and physician. *Health Educ Q* 1992;19:157–75.)

coded themes independently to assure consistency. The order of coding transcripts was random. Topics within themes were classified by highlighting the key words used by participants and then grouping into discrete categories. Finally, participants' phrases were identified to help illustrate themes and topics. Two coders (L.C. and L.A.) worked together to classify topics. A third coder (D.B., an epidemiologist), independently classified all topics.

Coding categories and interrater agreement for each category is presented in Table 1. Please note that the barriers and strategies are listed in parallel columns, but the columns should be read independently. Categories are listed in parallel columns. Themes and topics for barriers to HRT counseling are listed in the left hand column. Applying the chance-corrected κ coefficient,[16] interrater agreement before consensus was excellent (κ range, 0.87–0.96). Themes and topics regarding strategies to promote counseling are listed in the right hand column. Interrater agreement before consensus was good (κ range, 0.70–1.00) (1.00 = complete agreement). Data reported herein were established by coder consensus.

The final phase of the analysis involved determining the similarities and contrasts among the groups, including gender contrasts. The unit of analysis in focus group research is the group rather than the individual.[12] We examined themes from all six groups to identify themes pertinent to most groups rather than idiosyncratic themes. A theme was classified as major if it occurred in five or more groups. For each major theme, topics describing the content of that theme were then examined. A topic was considered primary if it was identified in four or more groups. For gender contrasts, themes or topics were considered major if they were found among two or more groups within one gender category but not the other.

## RESULTS

Results are summarized into the following areas: (1) HRT counseling in current practice, (2) implementation of the United States Task Force counseling recommendation, and (3) gender comparisons. Major themes and primary topics independently identified and discussed in the focus groups are listed in Table 2.

### Current practice

Three major barriers to counseling about HRT were identified as information, unique challenges, and resources (Table 2). The first barrier, at the individual level, was the need for information about HRT. Participants noted that information about the risks and benefits of therapy was either lacking or confusing. A second barrier, at the relational level, was the unique challenges presented by HRT counseling. Specifically, participants said that the beliefs and expectations brought to the visit and the uncertainly of the outcomes created distinct difficulties in counseling about HRT. The third barrier, at the organizational level, concerned lack of resources. Lack of educational materials and time and support staff were noted as major impediments.

Among the strategies identified for promoting counseling in current practice, patient education materials dominated (Table 2). Specifically, participants indicated that they wanted both print and audiovisual materials. Suggestions centered on developing materials to distribute before or during clinic visits.

### United States Task Force counseling recommendation

The two major barriers that were articulated in connection with implementing the United States Task Force recommendation were lack of information and lack of

**TABLE 1.** *Coding categories and reliability*

| Level of influence[a] | |
|---|---|
| Themes for Perceived Barriers[b] — Topics | Themes for Recommended Strategies[b] — Topics |
| **Individual-level-factors** | |
| Information ($\kappa^c = 0.87$ & $0.90$)[d] | Patient education ($\kappa^c = 0.70$ & $0.74$)[d] |
| Information is lacking | Written materials |
| Information is confusing | Audiovisual aids[e] |
| Information is changing | Resource center |
| | Social support groups |
| | Peer education[e] |
| Concerns of women ($\kappa^c = 0.95$ & –)[d,f] | Clinician reminders ($\kappa^c$ =–[f] & $0.75$)[d] |
| Side effects of hormone replacement therapy | Automated reminders |
| Taking hormones is not natural[g] | Special intake forms |
| Competing priorities | |
| Negative past experiences with hormones | |
| **Relationship-level factors** | |
| Unique challenges ($\kappa^c = 0.93$ &–[f])[d] | Clinic programs ($\kappa^c$ = –[f] & $1.0$)[d] |
| Beliefs and expectations | Staff counseling |
| Uncertainty of outcomes[g] | Telephone counseling[e] |
| Decision-making process is ongoing | Speciality clinic |
| Ensuring patient autonomy[e] | Consultative service |
| **Organizational-level factors** | |
| Resources ($\kappa^c = 0.96$ & $0.95$)[d] | Policy interventions ($\kappa^c$ = –[f] & $1.0$)[d] |
| Need for educational materials[g] | Guideline development |
| Lack of time and staff | Restructure patient panel[e] |
| Not included in productivity[e] | |
| Lack of outreach activities | |
| Not reimbursable (e.g., services) | |

[a] Based on the conceptual framework of Walsh and McPhee.[13]
[b] Barriers and strategies assessed by independent questions and should be read as separate columns.
[c] Chance-corrected κ coefficient.
[d] κ for current practice and United States Preventive Services Task Force recommendation, respectively.
[e] This category was unique to the discussion of United States Preventive Services Task Force recommendation.
[f] Insufficient data to calculate κ.
[g] This category was unique to the discussion of current practice.

**TABLE 2.** *Current practice: major themes and topics*[a]

| Level of influence[b] | |
|---|---|
| Perceived barriers[c] | Recommended strategies[c] |
| **Individual level** | |
| Information | Patient education |
| Information is lacking | Written materials |
| Information is confusing | Audiovisual aids |
| **Relationship level** | |
| Unique challenges | No major themes |
| Beliefs and expectations | |
| Uncertainty of outcomes | |
| **Organizational level** | |
| Resources | No major themes |
| Educational materials are lacking | |
| Time and support staff are lacking | |

[a] Identification of major themes (i.e., present in five or more groups) and topics (i.e., issue within a major theme that was described by four or more groups).
[b] Based on the conceptual framework of Walsh and McPhee.[13]
[c] Barriers and strategies assessed by separate questions and should be read as independent columns.

**TABLE 3.** *United States Preventive Services Task Force HRT counseling recommendation: major themes and topics*[a]

| Level of influence[b] | |
|---|---|
| Perceived barriers[c] | Recommended strategies[b,c] |
| **Individual level** | |
| Information | Patient education |
| Information is lacking | Written materials |
| Information is confusing | Discussion groups |
| | Clinician reminders |
| | Automated reminders |
| **Relationship level** | |
| No major themes | Clinic programs |
| | Staff counseling |
| | Specialty clinic |
| **Organizational level** | |
| Resources | Policy interventions |
| Lack of time and staff | Restructuring patient panel |

[a] Identification of major themes (i.e., present in five or more groups) and topics (i.e., issue within a major theme that was described by four or more groups).
[b] Based on the conceptual framework of Walsh and McPhee.[13]
[c] Barriers and strategies assessed by separate questions and should be read as independent columns.

resources (Table 3). At the individual level, the first barrier concerned the need for information about HRT. Again, participants noted that information about the risks and benefits of therapy was either lacking or confusing. At the organizational level, the second barrier centered on resources, specifically, the lack of time and staff to provide counseling to eligible women.

Four major strategies emerged regarding implementing the United States Task Force recommendation: (1) patient education, (2) clinician reminders, (3) clinic programs, and (4) policy interventions (Table 3). Patient education refers to strategies aimed specifically at women. The two desired strategies were the develop-

ment and distribution of print materials and the formation of discussion groups. Clinician reminders refer to the development of automated reminder systems, and this was the preferred strategy to remind individual providers to conduct counseling. Clinic programs refer to strategies aimed at promoting counseling outside the routine clinic visit. Participants suggested the development of innovative educational and counseling services to women conducted by nonphysician providers. Additionally, they wanted HRT counseling to be incorporated into established centralized programs for women, such as the breast and cervical screening program. Policy interventions refer to strategies aimed at changing the organization of the practice. The restructuring of providers' clinical panels was identified as the key organizational intervention to promote counseling. Specific suggestions focused on decreasing the size of the panel and allowing for longer clinic visits in which to conduct counseling.

### Comparison by gender

When we compared men's and women's focus groups, one distinction was found in current practice. All three women's groups cited staff counseling to support HRT counseling in current practice, whereas none of the men's focus groups made that suggestion (data not shown).

## DISCUSSION

Major barriers to HRT counseling are lack of information and provision of needed resources. The major strategies suggested to promote counseling in current practice include the development of patient education materials. Discussions of the issues involved in implementing the United States Task Force HRT counseling recommendation included the need for multiple supportive strategies. These strategies include patient education, clinical reminders, clinic programs, and policy interventions. Thus, when the focus moved from counseling in everyday practice to counseling all eligible women, the need for supportive strategies at all levels dominated the discussion. Previous work by Livingston et al.[8] found that clinicians desired educational materials and lacked time to discuss menopause with their patients. However, the work of Livingston et al.[8] focused largely on menopause.

Our findings have practical implications for developing interventions to support HRT counseling in everyday practice. Because the need for information was a leading concern, strategies should include developing and testing educational materials that can assist women in interpreting relevant information before having a discussion with their healthcare provider. For example, a handbook could be designed with information tailored to the woman's preferences, risks, and benefits and possible options to discuss with her healthcare provider. Given the need for healthcare providers to understand the beliefs and expectations of women, self-assessment tools could be incorporated into a handbook. Results from these tools could be shared with providers and could assist women in having a meaningful discussion about HRT. Using the findings from this investigation combined with a previous survey of women,[17] we are developing and testing such a handbook for older women at Group Health Cooperative.

Efforts to implement the United States Preventive Services Task Force recommendation on HRT counseling are likely to require a broad-based set of interventions carried out simultaneously at several levels. Our findings show that physicians wanted changes at the individual, relational, and organizational level. These findings are consistent with prior work indicating that implementing policy changes requires system-wide efforts by the organization, healthcare providers, and patients.[18]

Limitations of the present research should be noted. As with other methods, focus group research has the potential for self-selection bias. The success of focus group methods resides in dynamic interaction among participants who stimulate and challenge each other.[19] Thus, participants who are recruited have an interest in discussing the topic. Focus groups allowed us to bring physicians from different practice sites together, permitting interactions among peers outside the usual clinical setting and creating a much richer discussion.[20] Focus groups do not have the anonymity of survey methods that can be advantageous for certain topics. However, this did not appear to inhibit the expression of participants' personal concerns and struggles with counseling about HRT. In contrast to survey methods, which are often limited to the strategies identified by the investigators, focus groups allowed participants to generate their own strategies for promoting HRT counseling. It is unknown whether the individual strategies identified by providers in a managed care setting would generalize to fee-for-service settings.

Four distinct features of this study strengthen our confidence in the findings. First, care was taken to develop and pretest the discussion guide. Second, the interviews were conducted by trained moderators. Third, the coding system was guided by theory. The model of Walsh and McPhee[13] served as an important framework for this study. Finally, we explicitly assessed the interrater reliability for coding. These issues are too often ignored in qualitative research studies.

One of the most persistent challenges in clinical intervention research has been obtaining the explicit approval of clinicians for whom the program is designed to assist.[21] One means to promote buy-in is to first ascertain their perceptions about the issues and address these issues when designing interventions. Well-conducted and carefully analyzed focus groups, like these, serve as a practical and useful method to elicit information about the barriers to and strategies for the promotion of many United States Preventive Services Task Force counseling recommendations. We expect the strategies identified to be supportive of future efforts to promote counseling.

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