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MOTION BY SUPERVISOR LINDSEY P. HORVATH August 11, 2026

Ensuring Best Practices for Menopause Education and Treatment

Over the past few decades, there have been many advancements made in the field of menopause care to provide the least negative impact on people's lives and livelihoods. As clinical research and public opinion on hormonal treatment for menopause care have swayed in both directions of support and opposition, usage of this care has swayed as well. Los Angeles County (County) employs thousands of providers in several departments that deliver clinical and social services to clients. As such, these providers should have up to date, clinically-sound, evidence-informed, in-language, and culturally relevant information to convey to clients as they navigate through menopause and seek care for this natural, yet sometimes debilitating, stage of life.

Menopause is a diagnosable, single period of time when a person has gone 12 consecutive months without a menstrual period. The average age of diagnosis is 52 years old but can vary widely. Menopause symptoms can occur for several years before and after halting of the menstrual cycle as estrogen levels in the body deplete. The stages of menopause (perimenopause, menopause, and postmenopause) are natural processes for all people with ovaries, but an individual's experience and symptoms can vary widely, as well. Symptoms include, but are not limited to, vasomotor symptoms (hot flashes, night

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sweats), sleep disruption, common mental health disorders (CMHDs), mood swings, brain fog, weight gain, Genitourinary Syndrome of Menopause (GSM), thinning hair, musculoskeletal syndrome, and bone loss. Over half of menopausal individuals will experience symptoms of some kind. Behavioral health symptoms can present, and be misdiagnosed, as stemming strictly from a mental health standpoint rather than as a symptom of menopause. Without proper education and support, people going through menopause sometimes turn to substance use as a coping mechanism. One study found that almost a third of its participants drank alcohol to alleviate menopause symptoms.[1] This affects the diagnosis and treatment options presented to patients, which is why it is important to look at patients holistically to inform the proper diagnosis and the most effective treatment options.

Common treatment options for menopause include behavioral health therapy and hormone therapy (HT), also known as menopause hormone therapy (MHT). MHT is multifaceted and complex but has been shown to provide relief in patients experiencing a wide range of symptoms. MHT is commonly split into two types of therapies. Estrogen therapy (ET) only is used for people without a uterus, and combination estrogen and progesterone therapy (EPT) is used for people who still have a uterus. Progesterone is included for those with a uterus to reduce the chances of uterine cancer since it acts as a counteracting agent to endometrial over-growth. MHT is then commonly split into four methods of delivery: oral pills, transdermal methods (patches, gels, sprays), injections, and intrauterine/intravaginal devices (IUDs/IVDs). Depending on a patient's symptoms, one or more forms of MHT may be needed for the most optimal treatment.[2] Cultural

[1] Reisel, D., Kamal, A., Glynne, S., & Newson, L. (2024). Menopause and Risk-Taking Behaviours: A Cross-Sectional, Online Survey. *BJPsych Open*, *10*(S1), S74–S74. doi:10.1192/bjo.2024.232
[2] https://my.clevelandclinic.org/health/diseases/21841-menopause

background, racial/ethnic identity, personal values, lifestyle, and access to information and health care can all shape how someone understands and manages menopause.

Menopause can cause more issues than just debilitating symptoms; it can also lead to major financial impacts on patients and society. Patients experiencing menopause cause them to pay more in healthcare costs, especially when undiagnosed. The Mayo Clinic estimates menopause-related healthcare costs exceed $24 billion and workplace productivity loss to about $1.8 billion. Menopause can also lead to wage losses and premature exits from the workforce.

Scientific research of women, especially older women, is notoriously scarce in abundance and funding. As such, research on menopause and MHT does not have a very long history. MHT was growing in use until a 2002 Women's Health Initiative (WHI) halted short their clinical trial of MHT, warning that MHT was causing blood clots, heart attacks, stroke, and breast cancer in subjects. This led to a massive decline in prescribed MHT products and growing consensus that MHT was more dangerous than it was safe or beneficial. These conclusions were misleading because the WHI study only included oral pill MHT and mainly saw these effects in older women.[3] It has taken many years, but MHT has had a resurgence in its use, with prescriptions more than doubling from 2018 to 2026. This is because of several factors, including a growing body of evidence showing the safety and efficacy of MHT, prominent public figures opening up the conversation about MHT, and a November 2025 decision by the FDA to remove the "black box" warning (their most prominent safety warning) off certain hormone products.[4]

Though there is an increase in beneficial awareness and action, there is still both a large amount of misinformation, and lack of information in general, about

[3] Arnautu, et al. (2025). Menopausal Hormone Therapy-Risks, Benefits and Emerging Options: A Narrative Review. *International journal of molecular sciences*, *26*(22), 11098. https://doi.org/10.3390/ijms262211098
[4] https://www.truveta.com/blog/research/estrogen-based-hormone-replacement-therapy/

perimenopause and menopause as well as treatment options. County providers meet clients at all stages of life and for a wide array of needs. Providers should be aware of the most recent evidence-based science around identifying menopause symptoms and the abundance of treatment options that are both safe and effective. This will benefit the healthcare system, the workforce, and most importantly, those seeking care for some of the debilitating symptoms of menopause. It is important to elevate dialogue around the menopausal transition, normalize the experience, reduce stigma, and empower people with knowledge to make informed choices about their health.

I, THEREFORE, MOVE that the Board of Supervisors direct the Departments of Health Services (DHS) Public Health (DPH), and Mental Health (DMH) to report back to the Board in writing in 120 days on:

1. A plan and any current practices already in place to educate client-facing staff and providers on:
    a. The most recent, peer-reviewed and evidence-based materials regarding menopause, perimenopause, and postmenopause;
    b. The mental and physical effects that menopause can have on the body;
    c. How to properly recognize and/or diagnose someone with menopause;
    d. Safe and effective hormone treatment options for people experiencing adverse effects from menopause, including but not limited to, transdermal delivery (patches, gels, sprays), oral medications, injectables, intrauterine/intravaginal devices (IUDs/IVDs);
    e. Referral pathways for patients seeking more specified menopause care;

f. Educational, culturally responsive information about non-medical interventions that provide comfort measures to address menopause; and

g. Culturally competent and medically coherent methods of educating clients and patients on the above information. Educational materials for patients and clients should be available in County threshold languages.

2. The department-specific operational plan for incorporating the trainings, prioritizing efficiency and efficacy in implementation, and a timeline for implementing the above trainings.

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