

A group care model for the purpose of menopausal education and support

By Jean M. Marino, APRN-CNP, NCMP, IF

Adolescent girls are encouraged to attend education classes regarding their transition through puberty. Pregnant women are encouraged to attend childbirth classes in anticipation of labor and birth. But what is available for women when they transition into menopause, another significant hormonal shift that affects a woman's health and is often accompanied by psychosocial changes? With the growing cost of health-care and the potential to improve outcomes with education, group care models are an attractive option. Recognizing a need for menopause education and support, I developed a menopause education and support group at University Hospitals Case Medical Center (UHCMC) in Cleveland, Ohio.

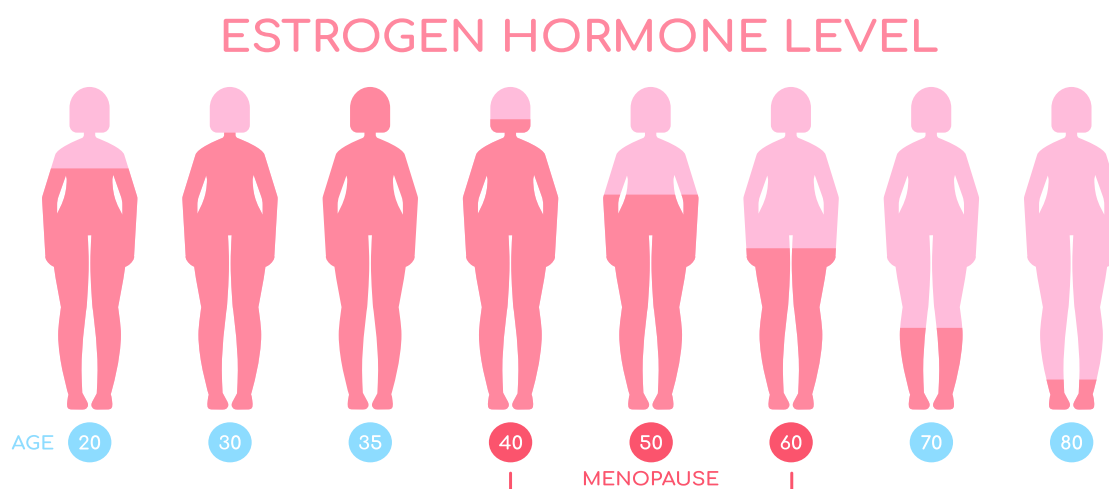
As background, it is worth noting that the average age of menopause is 51 years in North America, but anywhere from age 40 to 60 years is considered normal.

Currently, an estimated 64 million women are at least age 50 years in the United States. By 2060, it is estimated that this number will be 90 million women.¹

Although many women are aware that menopause can cause bothersome symptoms, most are unaware that they may start to have changes related to their fluctuating hormone levels, such as changes in mood and in bleeding pattern, vaginal dryness, or difficulty sleeping, up to 10 years before menopause. Menopause often coincides with other symptoms of aging, so a woman's health status can impact her reaction to menopause. In addition, a woman's reaction may be influenced by other midlife stresses such as financial and relationship changes or by her unique social and cultural circumstances. Consequently, a woman's response to menopause can range from relief to grief.

Regarding treatment of menopausal symptoms, hormone therapy (HT) has been an option. Women often have questions and concerns regarding the safety of HT, however, due to the very public results of the 2002 Women's Health Initiative.² Even though the North American Menopause Society (NAMS) published revised guidelines for hormone safety in 2017, many women are unaware of these.³ The new guidelines no longer recommend the smallest dose for the shortest amount of time, but rather to individualize dosage and length of time used to the patient. Also, the benefits of HT outweigh the risks for most women who are within 10 to 20 years of menopause. Menopause education, however, is more than just discussing the risks and benefits of HT.

As mentioned previously, menopause often coincides not only with physical changes but also with psychosocial changes. Many women find themselves in the "sand-



wich generation,” meaning they may be simultaneously taking care of dependent children and aging parents. Or they may be empty nesters for the first time and readjusting their relationship with a partner or adopting a new sense of self. With so many biologic and psychosocial changes associated with menopause, an education and support group for perimenopausal and menopausal women seemed long overdue.

I discussed my idea with an ob/gyn physician who was also interested in growing her midlife practice, and she immediately asked to be part of the group. She introduced me to a psychologist who was providing cognitive behavioral therapy (CBT) for bothersome menopausal symptoms and was interested in the group care model. A second psychologist who had heard about our beginning a menopause group expressed her interest. Therefore, I was able to create a multidisciplinary team that could provide comprehensive education and support.

I started with an informal survey of patients in my practice to gauge interest and availability. Questions I asked included: Would you be interested in being part of a menopause education/support group; what day of the week would you be able to attend and what time of day; and at what office location would you want it held? I brought the data to the chair of my department and discussed the ideas I had for the menopause group. He was very supportive and encouraged me to design the group. My team and I wanted to keep the group small, no more than 10 participants, so that participants would feel comfortable having open and honest discussions. The initial compensation for providers was to build up everyone’s individual practices and subsequent relative value units (RVUs). Even though the group numbers were small, I was not only concerned about getting enough participants but I also wanted to be mindful of the providers’ time because they were volunteering. So, I initially decided to offer our menopause group three times a year; for four 1-hour sessions. We meet on Monday evenings from 6 to 7 pm at an office location in a room set aside for education.

Determining a menopause curriculum was easy given the many topics available for discussion, and what better way to offer holistic care than with a multidisciplinary approach. I also felt strongly that we did not want the women to be lectured for an hour, but rather wanted to provide an opportunity for discussion and support. Although I devised a curriculum, I gauge the women’s interests and am flexible with the time we spend on any one topic. The team created the curriculum together and divided the topics based on every member’s strengths. I am at every group, but the other leaders are only at

Sample curriculum

Session 1

Welcome and introduction
Definition, changes leading up to menopause
Life changes, explore women’s feelings toward menopause
Menopausal symptoms:

- Mood, depression
- Sleep
- Hair/skin
- Memory

Session 2

- Breast cancer, risk/screening
- Gynecologic cancer, risk/screening
- Osteoporosis: screening, role of calcium and vitamin D, risk factors, treatment options
- Colon cancer, risk/screening

Session 3

Vasomotor symptoms
Hormonal therapy and selective estrogen receptor modulators
Nonhormonal options

- Non-evidence-based; weight loss/exercise, herbals
- Gabapentin
- Selective serotonin reuptake inhibitors
- Cognitive behavioral therapy and mindfulness

Session 4

- Heart disease and women; risk factors, screenings
- Weight gain
- Body image
- Nutrition
- Supplements

Session 5

- Hypoactive sexual desire disorder
- Genitourinary syndrome of menopause
- Growth and acceptance
- List of resources

group when they are presenting. The order of the topics may change based on everyone’s availability, although overall content is the same (see *Sample curriculum*).

The physician and I discuss HT, comparing and contrasting the different ways we prescribe. We discuss the results of the WHI study, risks and benefits of HT, safety data including how long a woman should stay on HT, and absolute contraindications to HT. We also discuss health screening recommendations for midlife women, such as breast cancer screening and cervical cancer screening, as well as medical conditions specific to midlife women, such as osteoporosis and gynecologic cancers. My favorite topic to discuss is the genitourinary syndrome of menopause (GSM). I review treatment options for GSM and healthy vulvovaginal hygiene. I discuss treatment for women with mild GSM, including over-the-counter options. For women with more moderate-to-severe symptoms, however, I recommend prescriptions that are both hormonal and nonhormonal. I spend time discussing the safety of the prescription options, why they have a black

box warning despite being local vaginal therapy, and the need for long-term use. I discuss that treatment for GSM needs to become part of their new vulvovaginal routine.

The two psychologist team members discuss sleep, memory, and mood changes that occur during the perimenopausal and menopausal periods. They discuss nonhormonal options for bothersome menopausal symptoms such as selective serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors, acupuncture, and CBT. Women's sexual health is discussed, with a focus on hypoactive sexual desire disorder. Prevalence, negative impact on women's lives, and treatment options are reviewed. Finally, they explore the women's perceptions about menopause by asking leading questions such as: "What words come to mind when you hear the word menopause?" They discuss how our culture has shaped how women perceive themselves and how they might alter any negative thoughts.

Initially, we had a total of four sessions, but feedback from the participants was that they wanted more information on weight and nutrition and there was too much information for only four sessions. So, we added a fifth session dedicated to heart disease, weight gain, and nutrition. A cardiology nurse practitioner and a registered dietician volunteered to lead that session. I felt it was crucial to make sure participants knew that heart disease is the number one killer of women and to review its risk factors and signs. Weight gain and nutrition are closely tied to heart disease, but outside of heart health, most women I have spoken with find the weight gain and changing body image associated with menopause distressing. We close our group with a list of resources

(see *Box*), when to call your provider, and a copy to each participant of the *Menopause Guidebook*.⁴

I have been leading this menopause education and support group for 4 years and have enjoyed many successes. In an effort to constantly improve the groups, I ask participants for written feedback after the last session. Examples of positive responses have been: "This group has helped me feel normal about my menopause symptoms. I no longer feel alone or crazy;" "I know I am normal. I know I have options. Life isn't over, just a little complicated;" "I know the questions to ask my provider;" and "I can relate to others going through the same thing." Some negative responses have included: "how short it was" and "I would like if my spouse participated, but I don't think he would attend." In fact, when brought up in group, several participants stated that they would like their spouse to attend. My next goal is to develop a menopause group session for women and their partners.

The two biggest challenges have been finances and marketing. When I first asked my department chair about developing a menopause group, I should have asked how UHMC would be willing to support it. Over the years, I have had two business analysts assist me with the group, but unfortunately their time and resources for my group were limited. Although the group was seen as being valuable for patient care, it was not seen as being lucrative and so I struggled with getting support, specifically for marketing. I did most of the leg work myself, reaching out to various writers for UHMC and asking them to come to my group and then write about it. I volunteered to give presentations both within the community and to the advanced practice providers at UHMC on menopause, asking them to consider referring patients to our group or attending themselves. I networked with colleagues and pharmaceutical reps about the group. I invited medical assistants and secretaries to come to the group so that they would be more willing to promote it to patients. More recently, I started an Instagram account to discuss women's health and more specifically menopause and advertise the group.

In addition to getting financial support for the group, it was difficult deciding on whether to charge or bill for the group. Currently, we charge \$40 for all five sessions, which covers the cost of the NAMS books and helps us have a budget for marketing. I tried billing insurance, but not only did I discover that insurance companies would not cover group education from a nurse practitioner but also that it did not generate RVU points. I did discover that leaders with a PhD can charge for group education. Those group leaders do not come to every session, however, and

Box. Our list of resources

Websites

American College of Obstetricians and Gynecologists:
www.acog.org^A

MiddlesexMD—maintain intimacy before and after menopause:
MiddlesexMD.com^B

North American Menopause Society (good place to find position statements): www.menopause.org^C

Apps

MenoPro App

Calcium calculator App

Books

Utian WH. *Change Your Menopause! Why One Size Does Not Fit All*.

Lesser E. *Broken Open: How Difficult Times Can Help Us Grow*.

Dalai Lama XIV, Tutu D, Abrams D. *The Book of Joy: Lasting Happiness in a Changing World*.

questions remain about whether they need to come to every group and whether it is OK to only bill some of the sessions. We have considered adding in basic assessments such as blood pressure, height, weight, and abdominal circumference so that insurance can be billed, but those assessments seem unnecessary for a weekly menopause education/support group. I have also received comments from providers within UHCMC about why I would charge or bill, as they believe it should be a free service. Finally, initially all of us were willing to volunteer our time for the groups to build up our menopause practices and earn a reputation for menopause care. Although we have been successful in these goals, I am now wondering how to get better compensated from UHCMC for our group. Perhaps it would be payment for our NAMS memberships, or payment to allow us to attend the NAMS annual conference? This continues to be a work in progress.

For anyone interested in starting a menopause group, NAMS has a book available for purchase: *How to Develop a Menopause Discussion Group*.⁵ Although published in 2002, it is still relevant. Here are also some of my own suggestions and tips:

- Determine if there is a need in your practice and community; consider collecting data
- Get support from your institution/colleagues; be specific about what that should look like
- Decide on the type of group care model. Is it a closed or an open group? Is it a discussion/support group or a shared medical appointment?
- Decide if participants will be charged and at what amount. Or will you bill insurance?
- Decide on a space and time. Consider parking, restrooms, and convenience of location. Be courteous of people's time and aim to start and end on time. This may involve intervening in the group to not allow one person to take over and staying on track. The two psychologists I work with are especially skilled at this.
- Select a team (ask nicely; pastries never hurt either). I recommend a multidisciplinary group and to design your curriculum around everyone's strengths. This includes gathering a team that will field phone calls about the group, complete registration, and do reminder phone calls.
- Determine your curriculum and how you want to supplement the teaching. We strive not to lecture and instead ask leading questions to encourage discussion. I show the women different prescription options for GSM and give out samples of lubricants received from drug reps. Showing videos might be an option, but in

my group, we do not have the time.

- Market and recruit for your group. Brainstorm on how to best reach your target audience. For me, giving presentations within UHCMC and the community has been very helpful.
- Get feedback from participants, asking for both positive and negative comments. We are constantly tweaking our group based on their feedback.
- Consider sustainability. How will you show the group's benefit to your institution? We received IRB approval to study our menopause group and had our research poster accepted at the NAMS 2019 conference, helping to give our group credibility within our institution.⁶ It has also been suggested that we track group participants through ambulatory electronic medical records to determine if they were more likely to schedule preventive appointments and screenings because of our group. ●

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Web resources

- A. acog.org/
- B. MiddlesexMD.com
- C. menopause.org/