"Patient-Centered Contraceptive Counseling: A Shared Decision Making Approach"

This engaging and informative webinar focuses on strategies for effective contraceptive counseling. The webinar, which was presented live in **June 2016** was facilitated by Dr. Christine Dehlendorf, MD, MAS, and sponsored by the NYC Department of Health and Mental Hygiene.

NYC Health

Patient-Centered Contraceptive Counseling

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Objectives

- Describe the rationale for using a patient-centered approach to contraceptive counseling
- List different models of counseling commonly used in family planning care, their strengths and weaknesses, and the evidence for their use, including shared decision making
- Demonstrate awareness of how to provide decision support around the choice of a contraceptive method
- Appreciate the potential role of unconscious bias in the provision of contraceptive counseling

Disclosures

- None to report

Patient-centered care

"Patient-centered care is care that is respectful of and responsive to individual patient preferences, needs, and values."

- Institute of Medicine

- Recognized by IOM as a dimension of quality
- Associated with improved outcomes

Communication is a key aspect of PCC

- Quality, patient-centered interpersonal communication is central to patient-centered care
  - Fosters positive, respectful, therapeutic relationships that enable patient to express needs and preferences
  - Ensures provision of appropriate education and counseling

What evidence is there that interpersonal communication matters?

- Interpersonal communication affects health care outcomes generally, including:
  - Patient satisfaction
  - Use of preventive care
  - Medication adherence

Doyle: *BMJ*, 2013

Evidence for impact of interpersonal communication in family planning

- Counseling influences method selection
- Quality of family planning counseling associated with use of contraception and satisfaction with method
- Client/patient-centered care is the right thing to do

Dehlendorf: *AJOG*, 2016
Rosenberg: *Fam Plann Perspect,* 1998
Forrest: *Fam Plann Perspect*, 1996
Harper: *Patient Ed Counsel*, 2010

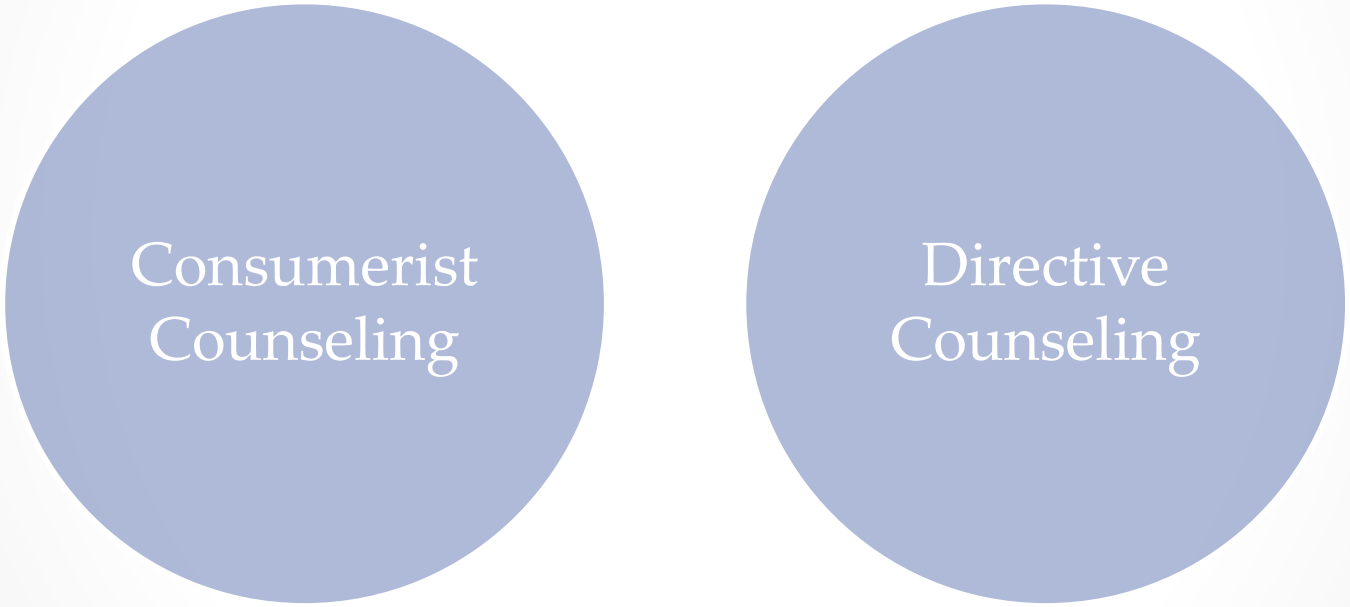
What are the stages of counseling?

1. Identifying need for contraception

2. Counseling about method options and selecting a method (i.e. contraceptive decision making)

3. Providing information about chosen method

Approaches to contraceptive decision making



Consumerist counseling

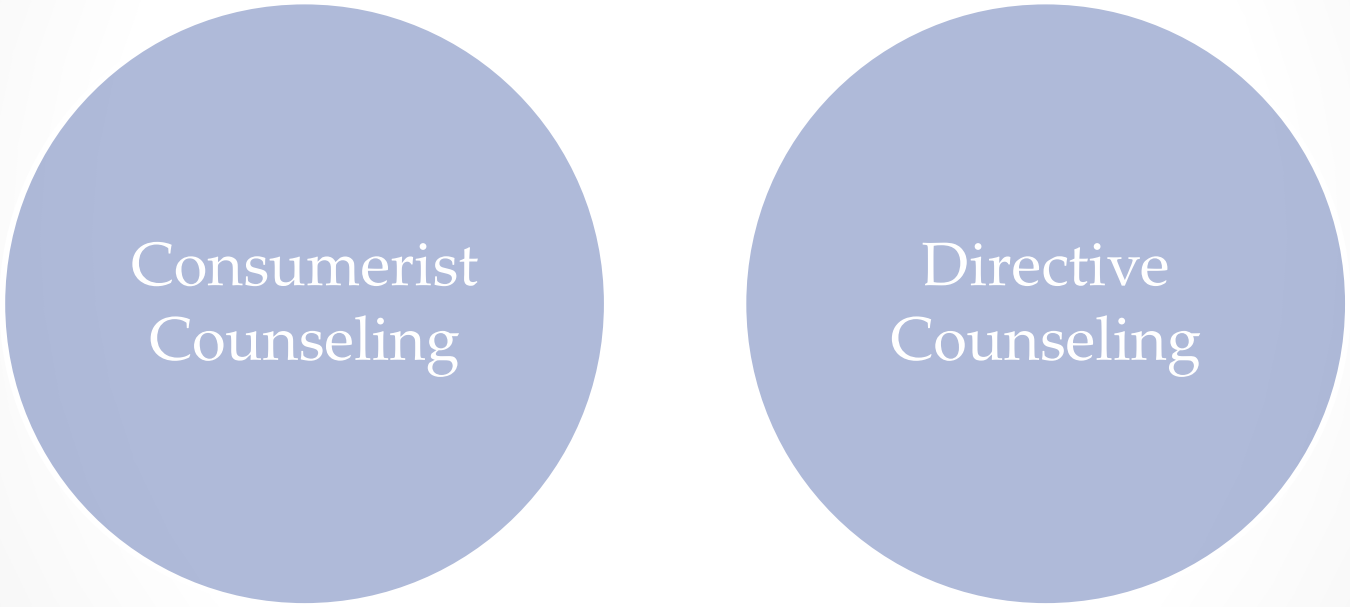
- Informed Choice:
  - Provides only objective information and does not participate in method/treatment selection itself
- Foreclosed:
  - Only information on methods asked about by the patient are discussed
- Both prioritize autonomy

Problems with consumerist counseling

- Informed Choice:
  - Provider does not assist patient in understanding how preferences relate to method characteristics or tailor information to patients needs

- Foreclosed:
  - Fails to ensure women are aware of and have accurate information about methods

Approaches to contraceptive decision making



Directive counseling

- Provides information and counseling designed to promote use of specific methods
- Rooted in the healthcare provider's preferences, or assumptions about the patient's priorities

Move Towards More Directive Approaches

- General emphasis on/promotion of LARC methods in family planning field

- Examples:
  - Tiered effectiveness: Present methods in order of effectiveness
  - Motivational interviewing: Patient-centered approach to achieving behavior change

Directive Counseling in Action

- Language among providers of "success" or "failure" in counseling based on whether patient selects a LARC method
- References by AAP and ACOG to LARC methods as "first line"
- Performance evaluations based on choice of LARC methods

Contraception: A preference-sensitive decision

- Preference-sensitive decisions are those where there is no one best option but involve tradeoffs among different outcomes of each treatment
- Women have strong and varied preferences for contraceptive features
- Relate to different assessments of potential outcomes, including pregnancy and side effects

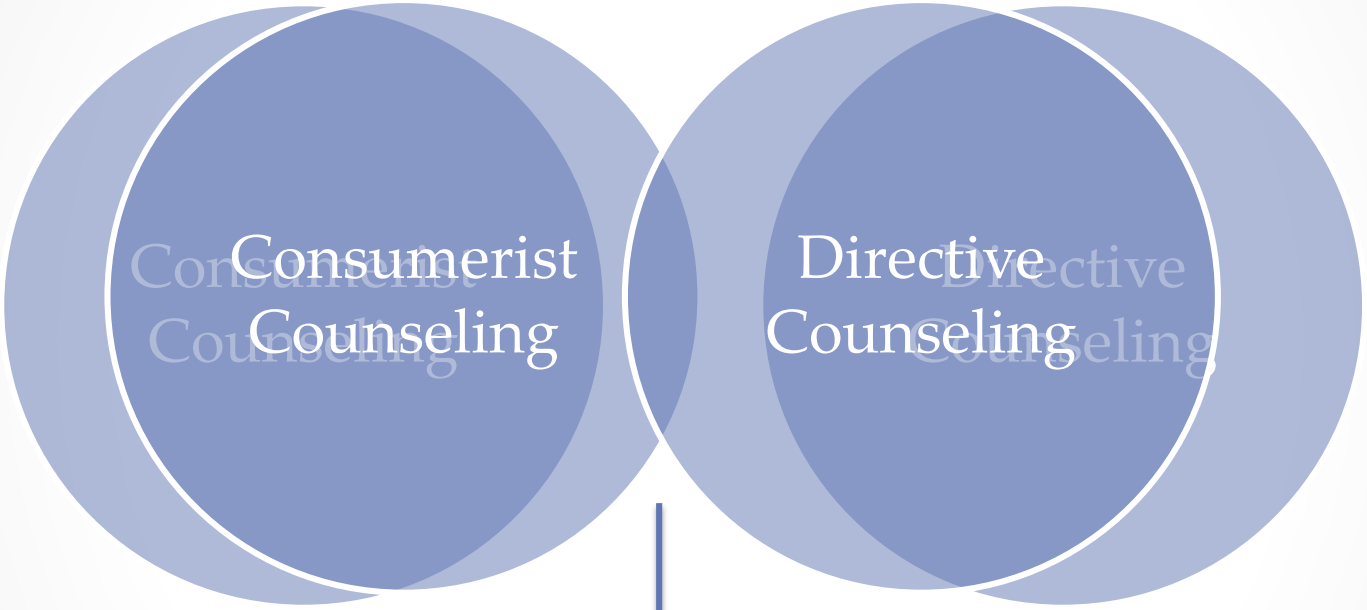
Lessard: *PSRH,* 2012
Madden: *AJOG*, 2015

Concerns with directive counseling approaches

- Assuming women should want to use certain methods:
  - Ignores variability in preferences
  - Does not prioritize autonomy
- Pressure to use specific methods can be counterproductive
  - Perceived pressure increases risk of method discontinuation

Kalmuss: *Fam Plann Perspect*, 1996
Pariani: *Stud Fam Plann*, 1991

Contraceptive decision making



Promote patient autonomy

Increase use of highly effective methods

Quality decision making

Shared decision making

patient preferences

Shared decision making

"A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences….This process provides patients with the support they need to make the best individualized care decisions."

- Informed Medical Decisions Foundation
- http://www.informedmedicaldecisions.org/what-is-shared-decision-making/

Shared decision-making in family planning

- Best method for an individual depends on her preferences
  - E.g., women will weigh effectiveness differently relative to other characteristics
- Consistent with women's preferences for counseling
- Associated with higher satisfaction with decision making process
- May not be best for everyone, but provides starting point for counseling

Dehlendorf: *Contraception*, 2013
Dehlendorf: unpublished data

Contraceptive Counseling and Disparities

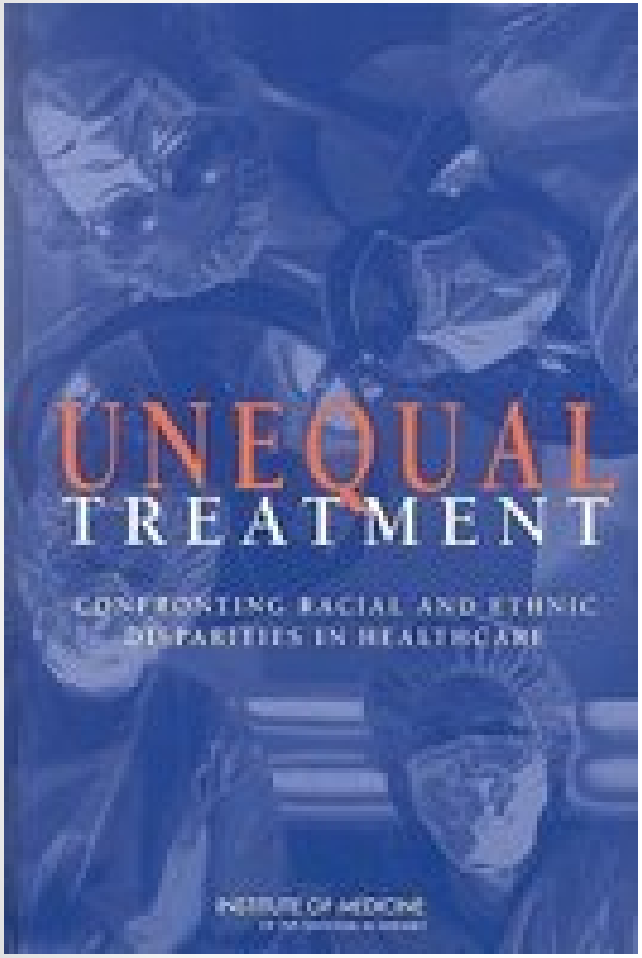
- History of contraceptive coercion in the US of women of color
- Stratified reproduction
  - The fertility of some people is valued by those who dominate social discourse and the fertility of other people is not
  - Formal and informal policies to limit the reproduction of some or encourage the reproduction of others
- Has implications for counseling

Trust in the Health Care System

- Potential for increased sensitivity regarding directive counseling
- 35% of Black women reported "medical and public health institutions use poor and minority people as guinea pigs to try out new birth control methods."
- Greater than 40% of Blacks and Latinas think government promotes birth control to limit minorities

Thorbun and Bogart, Women's Health, 2005

Provider bias



"…biases may exist…often unconsciously, among people who strongly endorse egalitarian principles and truly believe that they are not prejudiced. There is considerable empirical evidence that even well-intentioned whites…who do not believe that they are prejudiced demonstrate unconscious implicit negative racial attitudes and stereotypes [which] significantly shape interpersonal interactions….Evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care."

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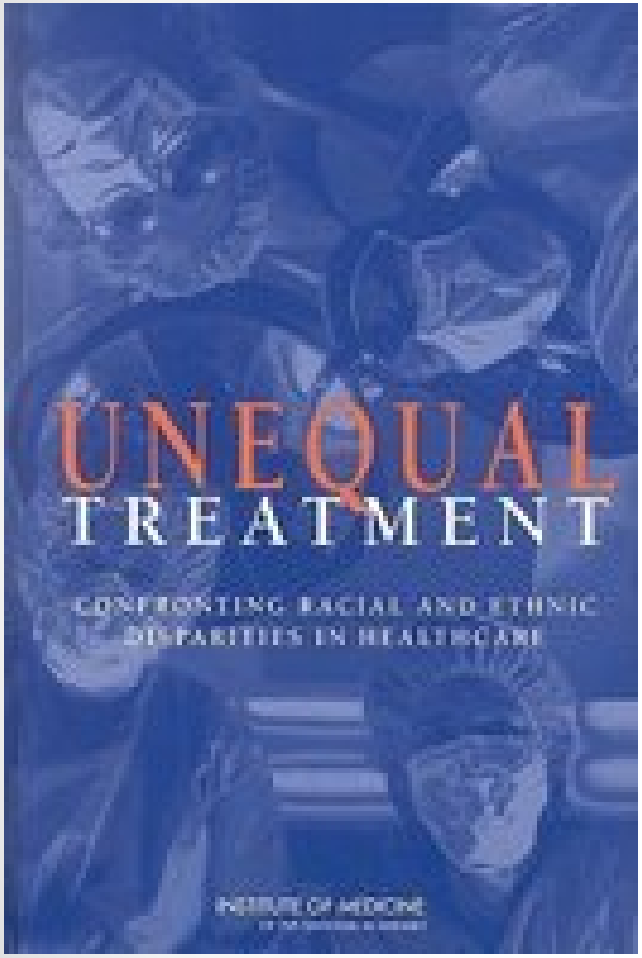

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UCSF

Provider bias

- Low-income women of color more likely to report being advised to limit their childbearing than were middle-class White women
- Blacks were more likely than Whites to report having been pressured by a clinician to use contraception
- In a survey of Black women, 28% reported being pressured to start one type of method when they preferred another

Downing: *Am J Public Health*, 2007
Becker: *Perspect Sex Reprod Health*, 2008
Thorburn: *Women Health*, 2005

Provider bias

- Providers are more likely to agree to sterilize minority and poor women
- Providers more likely to recommend IUDs to low SES black and Latina women than to low SES whites
- Family planning providers have lower levels of trust in their Black patients

Harrison: *Obstet Gynecol,* 1988
Dehlendorf: *Am J Obstet Gynecol*, 2010
Jackson, unpublished data

Counseling and Family Planning Disparities

- Given historical context and documented disparities in counseling, essential to ensure that providers focus on individual preferences when caring for women of color
- Shared decision making provides explicit framework for doing this, without swinging too far to other side
- Goal is to facilitate autonomous decision making based on patient preferences

How to Do Shared Decision Making in Contraceptive Counseling

The process of shared decision making

- Essential to establish a positive therapeutic relationship
- Women value intimacy and continuity
- "Investing in the beginning" → continuation
- But I already do that?
  - Greet patient warmly (only done in 65% of visits)
  - Small talk (only done in 45% of visits)
  - Open-ended questions (only done in 43% of visits)

UCSF

Dehlendorf: *Contraception*, 2013
Dehlendorf: *AJOG*, 2016

The process of shared decision making

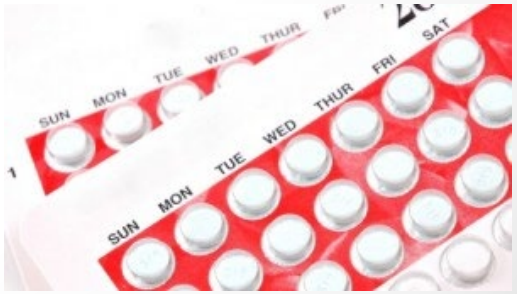
- Explicitly state focus on patient preferences:
  - "Do you have a sense of what is important to you about your method?"

- Elicit informed preferences for method characteristics:
  - Effectiveness
  - Frequency of using method
  - Different ways of taking methods
  - Return to fertility
  - Side effects

Don't assume women know about their options

- Provide context for different method characteristics
  - e.g. "There are methods you take once a day, once a week, once a month, or even less frequently. Is that something that makes a big difference to you?"

- Even if express strong interest in one method, ask for permission to provide information about other methods



Talking about effectiveness

- Effectiveness often very important to women
- Frequent misinformation or misconceptions about relative effectiveness of methods
- Effectiveness rarely mentioned
  - Only 21% of all visits in which IUDs mentioned
- Use natural frequencies:
  - Less than 1 in 100 women get pregnant on IUD
  - 9 in 100 women get pregnant on pill/patch/ring
- Use visual aids

Dehlendorf, PSRH, 2013

Effectiveness of Family Planning Methods

Most Effective

Less than 1 pregnancy per 100 women in a year

6-12 pregnancies per 100 women in a year

18 or more pregnancies per 100 women in a year

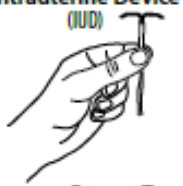
Least Effective

Reversible

Implant

0.05 %*

Intrauterine Device (IUD)



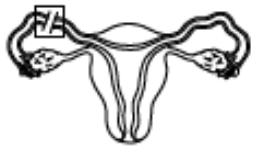
LNG - 0.2 % Copper T - 0.8 %

Permanent

Male Sterilization (Vasectomy)

0.15 %

Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)

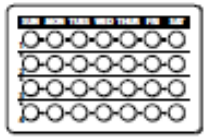


0.5 %

Injectable

6 %

Pill



9 %

Patch

9 %

Ring

9 %

Diaphragm

12 %

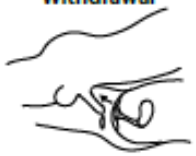
Male Condom

18 %

Female Condom

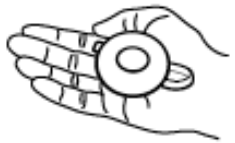
21 %

Withdrawal



22 %

Sponge

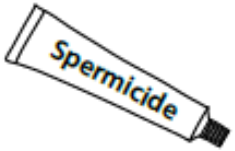


24 % parous women
12 % nulliparous women

Fertility-Awareness Based Methods

24 %

Spermicide



28 %

* The percentages indicate the number out of every 100 women who experienced an unintended pregnancy within the first year of typical use of each contraceptive method.

How to make your method most effective

After procedure, little or nothing to do or remember.

Vasectomy and hysteroscopic sterilization: Use another method for first 3 months.

Injectable: Get repeat injections on time.

Pills: Take a pill each day.

Patch, Ring: Keep in place, change on time.

Diaphragm: Use correctly every time you have sex.

Condoms, sponge, withdrawal, spermicides: Use correctly every time you have sex.

Fertility awareness-based methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be the easiest to use and consequently more effective.

CS 242797

CONDOMS SHOULD ALWAYS BE USED TO REDUCE THE RISK OF SEXUALLY TRANSMITTED INFECTIONS.

Other Methods of Contraception

Lactational Amenorrhea Method: LAM is a highly effective, temporary method of contraception.

Emergency Contraception: Emergency contraceptive pills or a copper IUD after unprotected intercourse substantially reduces risk of pregnancy.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Adapted from World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP). Knowledge for health project. Family planning: a global handbook for providers (2011 update). Baltimore, MD; Geneva, Switzerland: CCP and WHO; 2011; and Trussell J. Contraceptive failure in the United States. Contraception 2011;83:397–404.

Your Body. Your Birth Control.

Use this chart to review all available methods and understand which one best meets your priorities & preferences.

METHOD Options	 IUD (Non-hormonal)	 IUD (Hormonal)	 Implant	 Shot	 Vaginal Ring	 Patch	 Pill	 Condom
TYPICAL USE Effectiveness	**99%** effective	**99%** effective	**99%** effective	**94%** effective	**91%** effective	**91%** effective	**91%** effective	**82%** effective
HOW LONG Does it last	Up to 10 years	Up to 3 or 5 years	Up to 3 years	Up to 3 months	Up to 1 month	Up to 1 week	For 1 day	For 1 sex act
HOW DO YOU Get Started	Inserted by your provider	Inserted by your provider	Inserted by your provider	Shot given by your provider	Prescription from provider	Prescription from provider	Prescription from provider	Buy over the counter
WHAT DO YOU Need to Do	No action required	No action required	No action required	Get shot of provider every 3 months	You insert ring into vagina and replace every month	You place patch on body and replace every week	You take pill every day	You use condom for each sex act
POSSIBLE Bleeding Changes	Heavier periods that may return to normal after 3-6 months	Irregular, lighter, or no period at all	Infrequent, irregular, prolonged, or no period	Irregular or no period	Shorter, lighter, more predictable periods	Shorter, lighter, more predictable periods	Shorter, lighter, more predictable periods	None
POSSIBLE Side Effects	Cramping, that usually improves after 3-6 months, spotting	Cramping, during and after insertion, spotting	Insertion site pain	Weight changes	Nausea or breast tenderness	Nausea, breast tenderness, application site reaction	Nausea or breast tenderness	Allergic reaction to latex
IF STOPPED When Can you Get Pregnant	Immediately, schedule removal with provider	Immediately, schedule removal with provider	Immediately, schedule removal with provider	Immediately, but may have 6-12 month delay. No action required	Immediately, must remove ring from body	Immediately, must remove patch from body	Immediately, stop taking pills	Immediately, no action required

Only the condom protects against STIs and HIV. Talk with your provider about the best method for you.

Counseling about side effects

- Focus on menstrual side effects
- Inquire about particular other areas of interest or concern to patient
  - Previous experiences?
  - Things she has heard from friends?
- Providers often dismissive of patient concerns
  - Respond to patient concerns about side effects in a respectful manner
- Consider benefits (e.g., acne) as well

Levy, Women's Health Issues, 2015

Experiences of counseling about side effects

"I think that they hide the fact of the complications or the defects, the things that might happen if you take that. They don't give you that information and I don't think any provider has given me that information."

Dehlendorf: *Contraception*, 2013

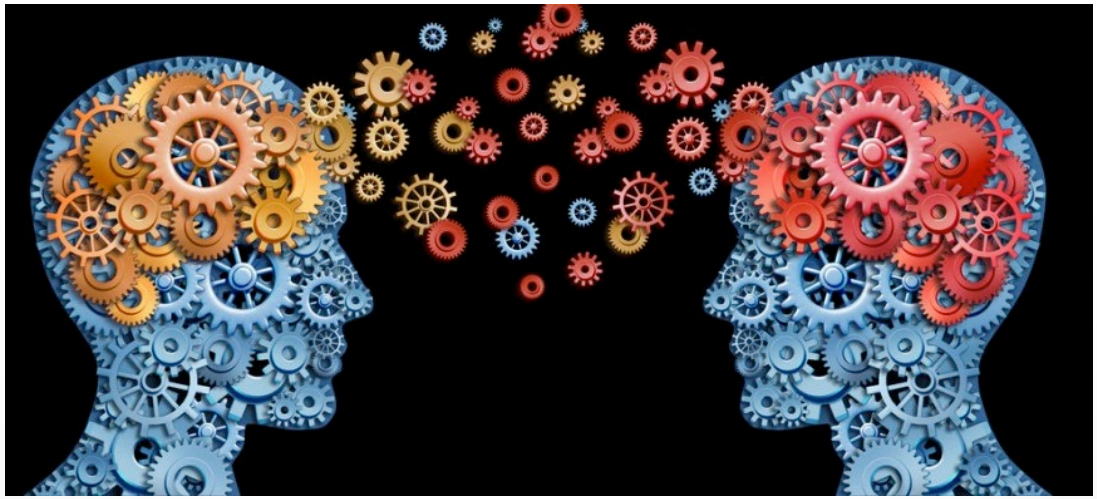
Addressing Patient's Concerns

"That's too bad your friend had that experience. I haven't heard of that before, and I can tell you it definitely doesn't happen frequently.

"Some women don't like the idea of not having a regular period for a range of reasons. But I do want to make sure you know that it is safe not to have a period when using these methods, in case safety is a concern for you."

Sharing decision making

- Provide scaffolding for decision making
  - Given their preferences, what information do they need?
  - Actively facilitate, while avoiding stating opinions not based on patient preferences



Examples of facilitation

"I am hearing you say that avoiding pregnancy is the most important thing to you right now. In that case, you may want to consider either an IUD or implant. Can I tell you more about those methods?"

"You mentioned that it is really important to you to not have irregular bleeding. The pill, patch, ring and copper IUD are good options, if you want to hear more about those."

Shared decision making

- Explicitly focus on patient preferences
- Elicit patient preferences with direct questioning
  - Provide context about options
- Provide scaffolding for decision making process
  - Iterative process focusing on information most relevant to the individual

Case Discussion

A 23 yo presents for an an abortion, her 6th. During the counseling session, when you ask her what she would like to use for birth control, she replies that she does not want to use anything. How would you proceed with this counseling session?

Patient-Centered Contraceptive Care and Abortion

- May have a desire to encourage contraceptive use in this patient
  - Specifically highly-effective methods
- However, this can conflict with a focus on providing the care that is consistent with her preferences
- Many women do not wish to discuss contraception at time of an abortion

Matulich: *Contraception*, 2014

Patient-Centered Contraceptive Care and Abortion

- Abortion care visit does provide opportunity to meet women's needs
- Focus on patient-centered communication can improve trust in family planning providers
- Ask if she would be interested in hearing information about available methods
  - Explicit focus on her needs and preferences, without investment in what she leaves with

Overcoming barriers to patient-centered care

- Foster awareness of one's own biases
  - Methods
  - Patient characteristics
- Use job aids/decision tools that facilitate patient-centered care
- Integrate patient-centeredness into all aspects of care

Resources

- www.bedsider.org
- Dehlendorf C, Krajewski C, Borrero S. Contraceptive counseling: best practices to ensure quality communication and enable effective contraceptive use. *Clin Obstet Gynecol* 2014; **57**(4): 659-73.
- Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. *Contraception* 2013; **88**(2): 250-6.
- Higgins JA. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception* 2014; **89**(4): 237-41.

Questions?