Using Shared Decision Making in Contraceptive Counseling

PWCC

Program in Woman-Centered Contraception

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Objectives

- Review the rationale for shared decision making in contraceptive counseling
- Understand how to engage in shared decision making
- Evaluate barriers to shared decision making and strategies to overcome them

What models of contraceptive counseling have you seen or heard of?

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

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/

Is SDM appropriate for contraceptive counseling?

- **Directive counseling** appropriate when there is one option that leads to better health outcomes
  - Smoking cessation
  - Diabetes control
- Providers can engage with patients' preferences in patient-centered manner, while having an agenda

- **Shared decision making** appropriate for preference-sensitive decisions, in which there is no one best option
  - Early breast cancer treatment
  - Early prostate cancer treatment
- Helps patient to consider tradeoffs among different outcomes of treatments

What kind of decision is contraceptive choice?

- Women have strong and varied preferences for contraceptive features
- Relate to different assessments of potential outcomes, such as side effects
- Also relates to different assessments of the importance of avoiding an unintended pregnancy

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

How do women think about pregnancy?

- **Intentions**: Timing-based ideas about if/when to get pregnant
- **Plans:** Decisions about when to get pregnant and formulation of actions
- **Desires:** Strength of inclination to get pregnant or avoid pregnancy
- **Feelings:** Emotional orientations towards pregnancy

Aiken, PSRH, 2016

A Multidimensional Concept

Plans ≠ Intentions ≠ Desires ≠ Feelings

- All different concepts
- Women may find all or only some meaningful
- Often appear inconsistent with each other

Effectiveness is not always the most important consideration

"I guess one of the reasons that I haven't gotten an IUD yet is like, I don't know, having one kid already and being in a long-term committed relationship, it takes the element of surprise out of when we would have our next kid, which I kind of want. I'm in that weird position. I just don't want to put too much thought and planning into when I have my next kid."

Higgins *et al*. In Preparation 2016

Shared decision-making in family planning

- Appropriate given contraceptive choice is a preference-sensitive decision
- Consistent with many women's preferences for counseling
- Patients who report sharing their decision with their provider had higher satisfaction with decision making process
  - Compared to both patient- and provider-driven decisions
- May not be best for everyone, but provides starting point for counseling

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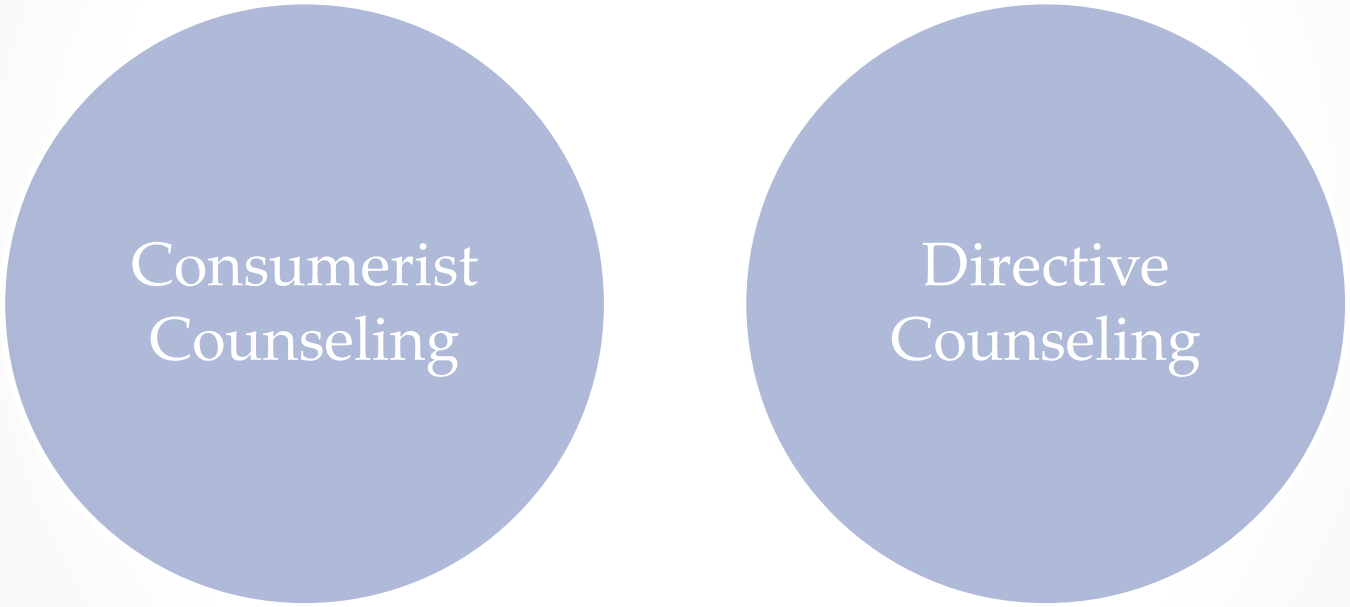
Dehlendorf, Contraception, 2014
Dehlendorf, Contraception, 2017

How does SDM relate to other models of contraceptive counseling?



Directive counseling

- Provides information and counseling designed to promote use of specific methods

- Rooted in the healthcare provider's preferences, or assumptions about the client's priorities

Move Towards More Directive Approaches

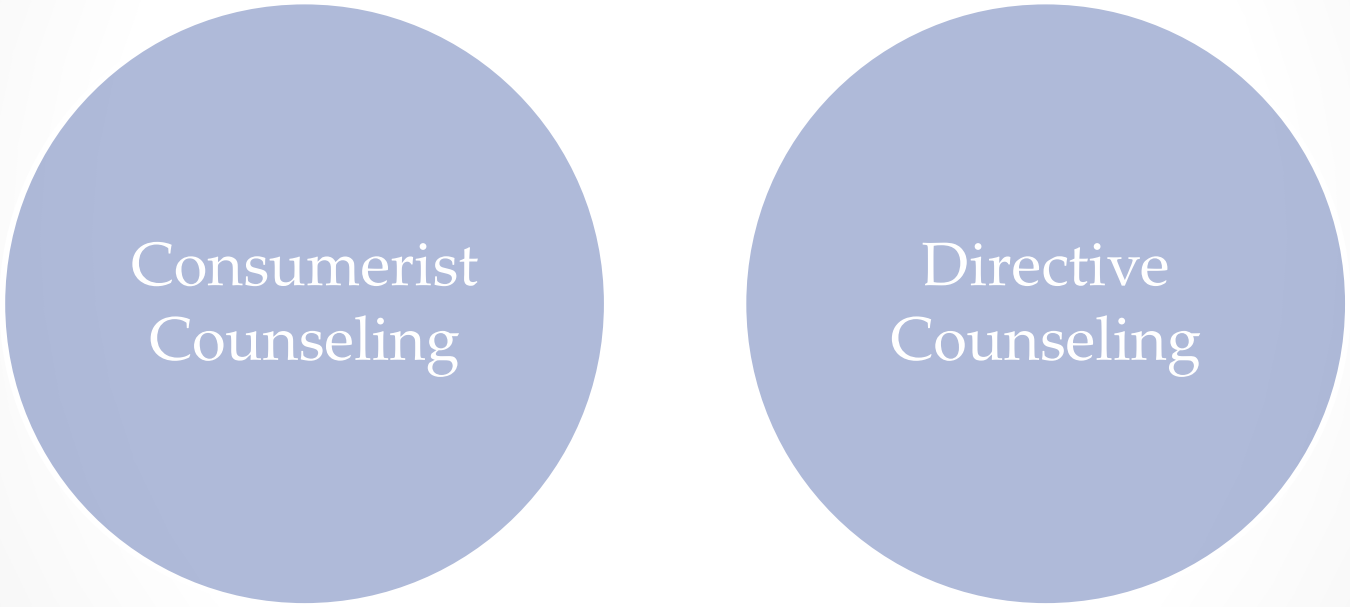
- General emphasis on/promotion of LARC methods in family planning field

- Examples:
  - Tiered effectiveness
  - Motivational interviewing

- Assuming women should want to use certain methods ignores variability in preferences

Have you seen directive counseling towards LARC in your own setting?

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

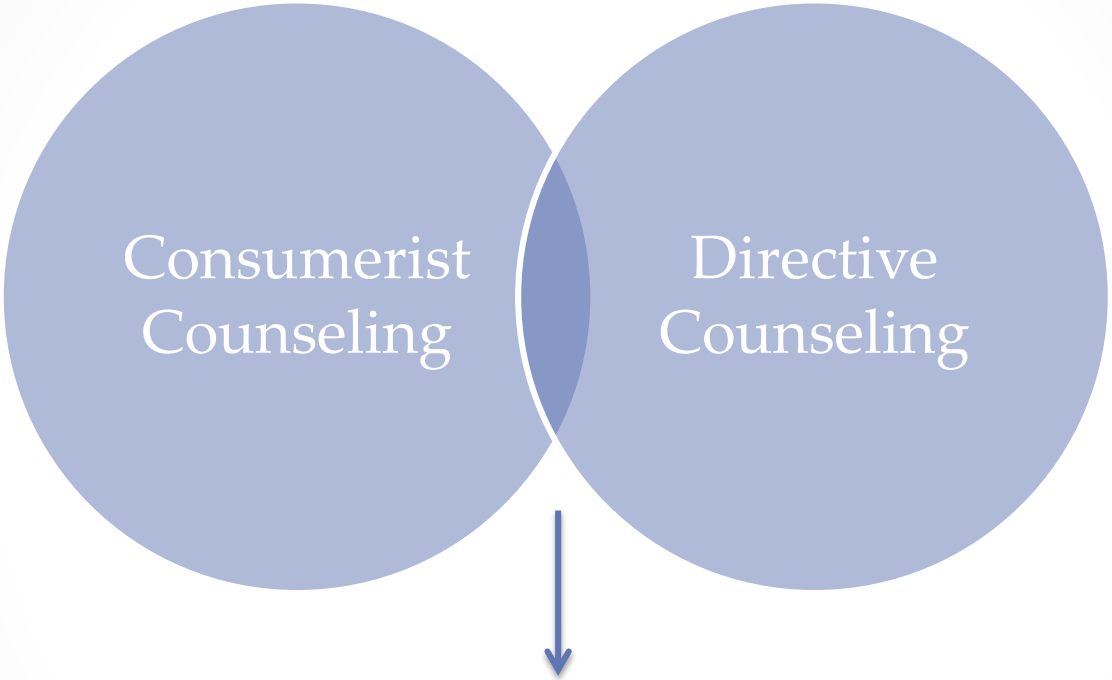
- Informed Choice:
  - Provider does not assist patient in understanding how preferences relate to method characteristics or tailor information to patient's needs
- Foreclosed:
  - Fails to ensure patient is aware of and has accurate information about methods

How do we provide patient-centered contraceptive care?

Promote patient autonomy

Increase use of highly effective methods

How do we provide patient-centered contraceptive care?



Quality decision based on patient preferences

Shared decision making

Jamie

- Jamie is a 21 yo G0P0 who presents to the family planning clinic requesting Depo-Provera for contraception. She has never used contraception before, but is considering becoming sexually active soon and wishes to initiate a new contraceptive method. Her friends use “the shot” and she thinks she would like this method. How would you counsel this patient?

Jamie: Possible Responses

1. Give her Depo without more counseling since this is her preference
2. Briefly check in to make sure she really wants the Depo before giving it to her
3. Elicit the reason for her preference and make sure she knows about her other options
4. It depends

Jamie: Learning points

- Can feel a tension between patient autonomy and ensuring there is an informed decision
- Should always start by acknowledging patient preferences
- Elicit rationale for preference in order to:
  - Evaluate whether it is an informed choice by assessing patient's preferences
  - Identify other possible appropriate methods
- Ask the patient for permission to discuss other methods of contraception that align with stated 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)

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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
  - Side effects
  - Frequency of using method
  - Different ways of taking methods

Don’t assume women know about their options

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



Don't assume women know about their options

- Provid teristics
-

"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?"

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Talking about effectiveness

- Effectiveness often very important to women
- Frequent misinformation or misconceptions about relative effectiveness of methods
- 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

Craig, WHI, 2014

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

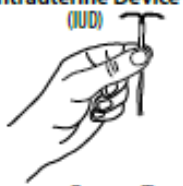
Least Effective

Reversible

Implant

0.05 %*

Intrauterine Device (IUD)



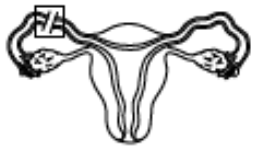
LNG - 0.2 % Copper T - 0.8 %

Permanent

Male Sterilization (Vasectomy)

0.15 %

Female Sterilization (Abdominal, Laparoscopic, Hysteroscopic)

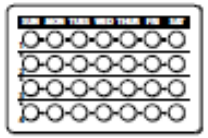


0.5 %

Injectable

6 %

Pill



9 %

Patch

9 %

Ring

9 %

Diaphragm

12 %

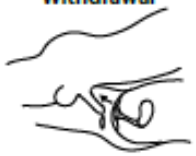
Male Condom

18 %

Female Condom

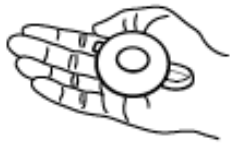
21 %

Withdrawal



22 %

Sponge

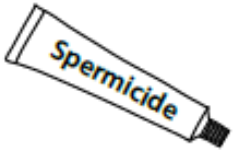


24 % parous women
12 % nulliparous women

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.

Patient-Centered Job Aid

Birth Control Method Options

Most Effective → Least Effective

	Female Sterilization	Male Sterilization	IUD	Implant	Injectables	Pill	Patch	Ring	Diaphragm	Male Condom	Female Condom	Withdrawal	Sponge	Fertility Awareness Based Methods	Spermicides
Risk of pregnancy*	.5 out of 100	.15 out of 100	LNG: .2 out of 100 CopperT: .8 out of 100	.05 out of 100	6 out of 100	9 out of 100			12 out of 100	18 out of 100	21 out of 100	22 out of 100	12–24 out of 100	24 out of 100	28 out of 100
How the method is used	Surgical procedure		Placement inside uterus	Placement into upper arm	Shot in arm, hip or under the skin	Take a pill	Put a patch on skin	Put a ring in vagina	Use with spermicide and put in vagina	Put over penis	Put inside vagina	Pull penis out of the vagina before ejaculation	Put inside vagina	Monitor fertility signs. Abstain or use condoms on fertile days.	Put inside vagina
How often the method is used	Permanent		Lasts up to 3–12 years	Lasts up to 3 years	Every 3 months	Every day at the same time	Each week	Each month	Every time you have sex					Daily	Every time you have sex
Menstrual side effects	None		LNG: Spotting, lighter or no periods CopperT: Heavier periods	Spotting, lighter or no periods	Spotting, lighter or no periods	Can cause spotting for the first few months. Periods may become lighter.			None						
Other possible side effects to discuss	Pain, bleeding, infection		Some pain with placement		May cause appetite increase/ weight gain	May have nausea and breast tenderness for the first few months.			Allergic reaction, irritation			None	Allergic reaction, irritation	None	Allergic reaction, irritation
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	Counsel all clients about the use of condoms to reduce the risk of STDs, including HIV infection.														

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

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May 2016

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?
- Respond to client concerns about side effects in a respectful manner
- Consider benefits (e.g., acne) as well

Dehlendorf: *Contraception*, 2013

Counseling about side effects

- Focus on menstrual side effects
- Inquire about [illegible] of interest or concer[illegible]
  - [illegible]
- [illegible] re[illegible]
- Consider benefi[illegible]

"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

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How can you address patient concerns?

"My friend said that method made her crazy."

"That's ridiculous. No studies have ever shown psychological effects of this method."

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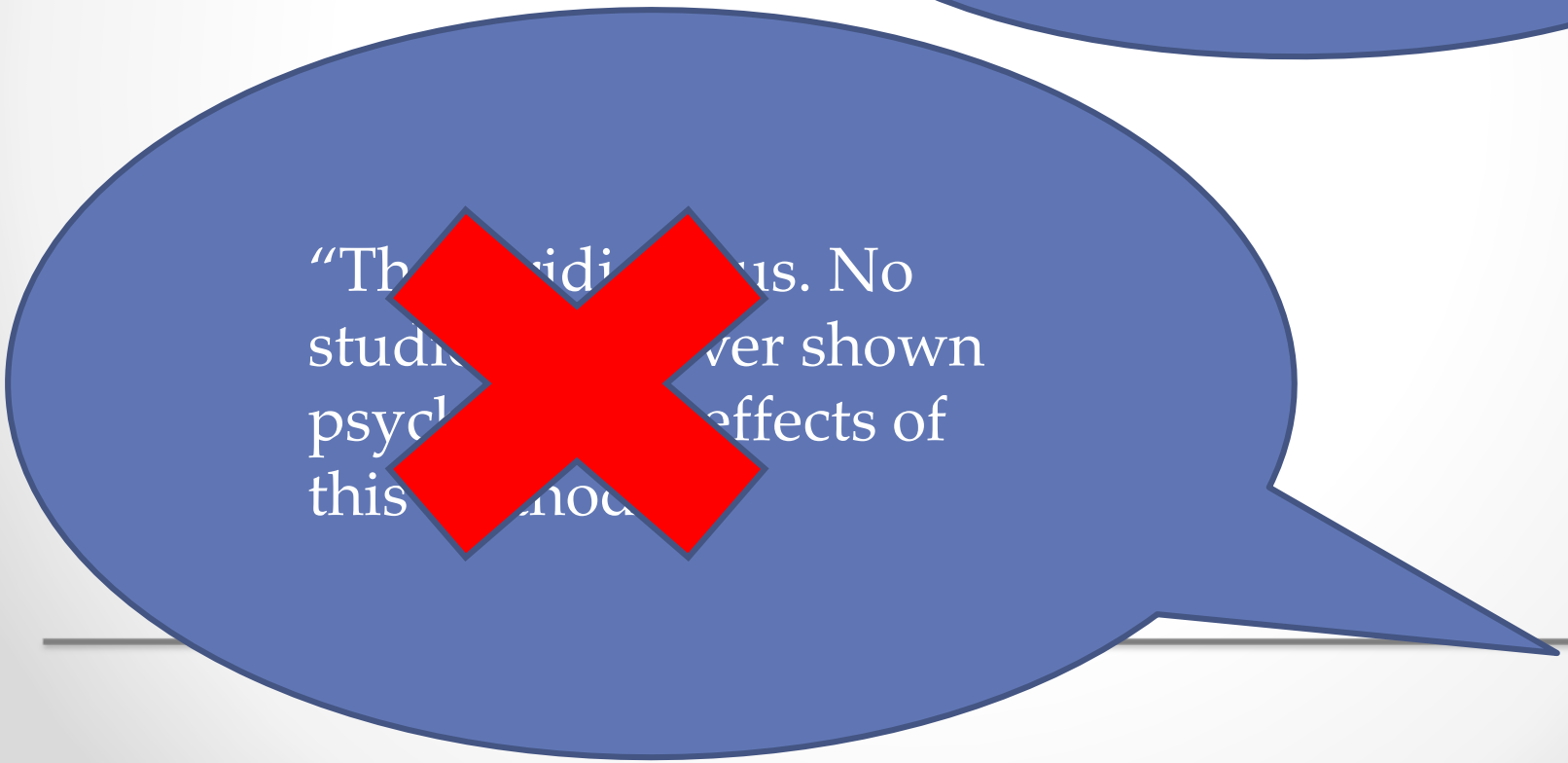


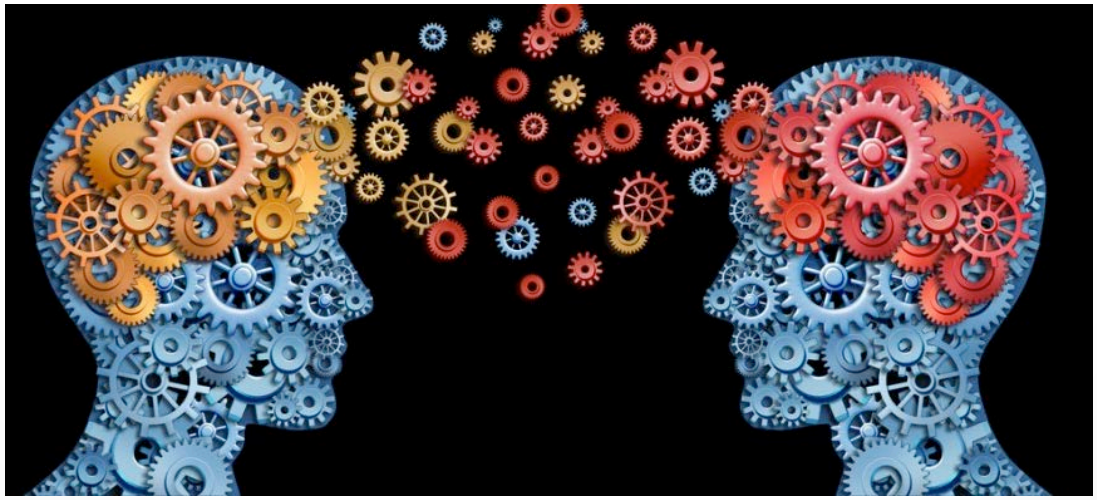
How can you address patient concerns?

"My friend said that method made her crazy."

"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."

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."

Patient-Centered Job Aid

Birth Control Method Options

Most Effective → Least Effective

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	Counsel all clients about the use of condoms to reduce the risk of STDs, including HIV infection.														

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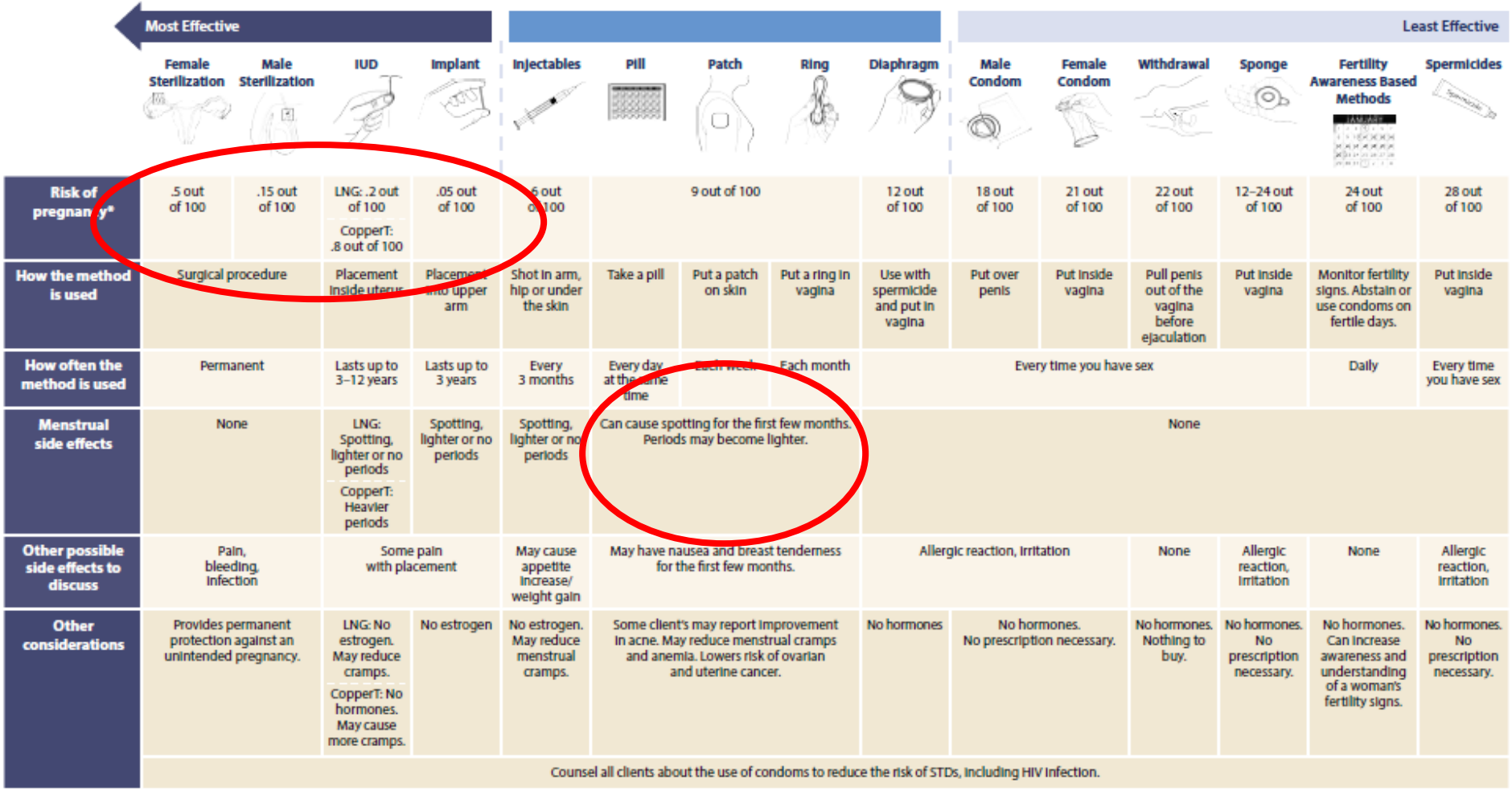
More complex cases

"I've heard from you that the absolute most important thing is not getting pregnant, and that you also want something that makes your period lighter but keeps it regular. Let's look at this chart to explore your options."

Discordant Preferences

Birth Control Method Options



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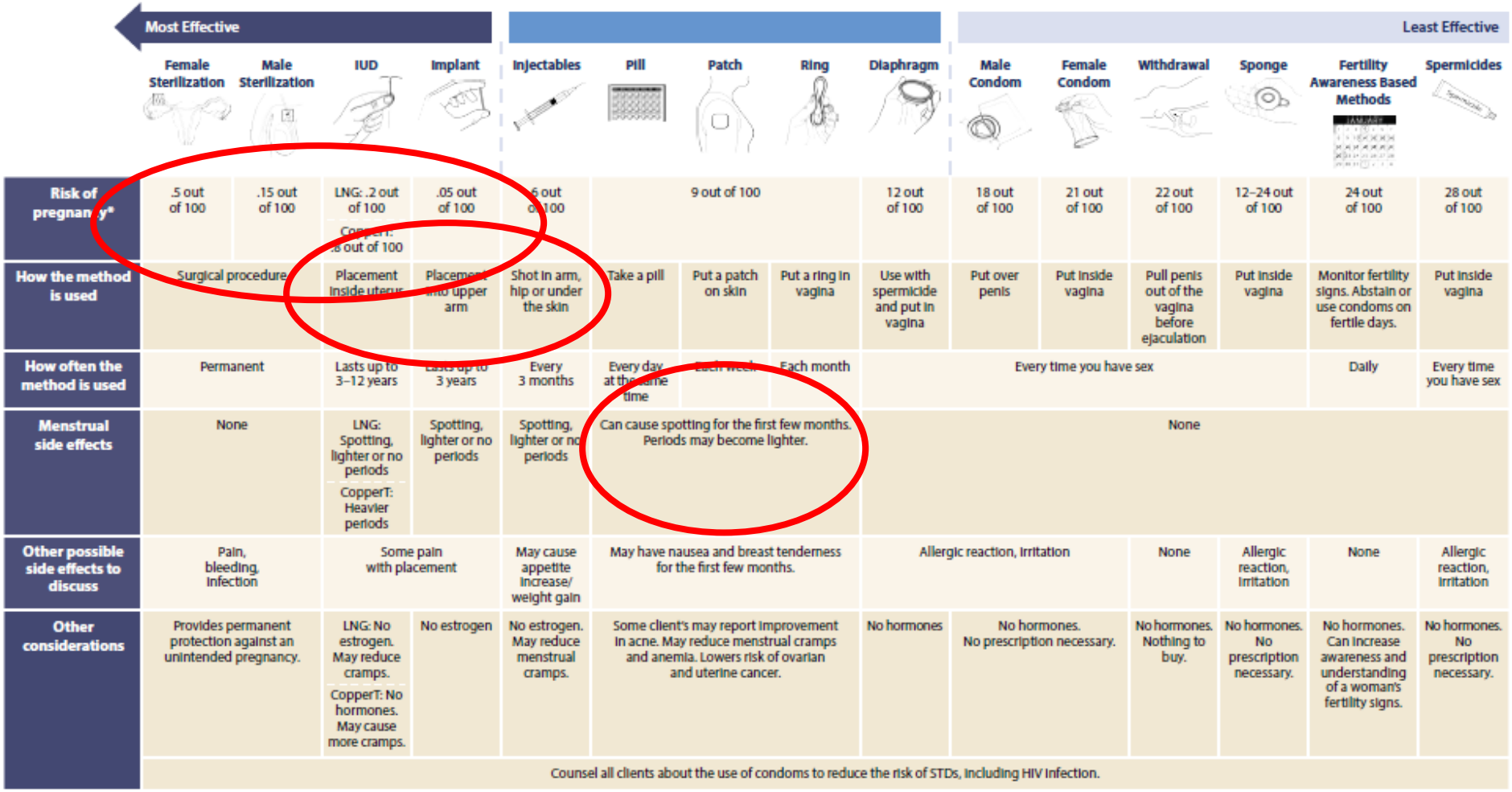
More complex cases

"I've heard from you that the absolute most important thing is not getting pregnant, and that you also want something that makes your period lighter but keeps it regular. Let's look at this chart to explore your options."

Client: "Which of these methods can I keep from my parents?"

Discordant Preferences

Birth Control Method Options



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What challenges may arise with this model of counseling?

- Concerns about time?
- Particular patient characteristics with whom this approach would be more difficult?

Mia

- An adolescent presents to the office for an annual well-visit. She is sexually active and currently uses condoms and withdrawal for contraception. She is satisfied with this method of contraception. How would you counsel this patient?

Mia: Learning points

- Establishing rapport is the most important first step!
- More tendency to be directive with adolescents
  - Need to prioritize autonomy
  - Providers being directive can elicit reaction in this age group
- Elicit the patients preferences surrounding method characteristics, including effectiveness
  - Evaluate if her contraceptive choice aligns with her stated goals
  - Provide education about relative effectiveness of methods as appropriate

What About Race/Ethnicity?

- Low-income women of color more likely to report being advised to limit their childbearing than middle-class white women
- Blacks were more likely than whites to report having been pressured by a clinician to use contraception
- 67% of black women reported race-based discrimination when receiving family planning care

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

Are Women of Color Counseled Differently?

- Family planning providers have lower levels of trust in their Black patients
- Providers are more likely to agree to sterilize women of color and poor women
- Providers more likely to recommend IUDs to poor women of color than poor white women

UCSF

Jackson, unpublished data
Harrison, Obstet Gynecol 1988
Dehlendorf, American Journal of Obstetrics and Gynecology, 2010

SDM and Race/Ethnicity

- Documented tendency for providers to have bias in counseling towards patients of color
  - Particularly concerning given historical context
- 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

Joann

- A 19 yo G2P2 presents to the clinic 5 months after she had an IUD inserted, requesting you remove it. She had thought she was done having children but began a new relationship 1 month ago and now is unsure if she wants to have more kids, but "wants to still have that option." How would you counsel this patient?

Joann: Learning points

- Tendency for high efficacy of IUD to motivate providers to promote continuation of this method
- Begin with assurance that will remove method at patient request
- SDM refocuses attention on woman's preferences
  - Side effects with method?
  - Fear about future fertility?
  - Desire for or ambivalence about pregnancy?
- Ensure patient preferences are well-informed and supported

Samantha

- Samantha is a 23 yo woman who comes to you for STI follow-up after her 6th abortion. When you ask her if she would like to discuss birth control at this visit she replies, “No” and makes it clear she does not wish to discuss this further. How would you proceed?

Samantha: Learning points

- May have a desire to encourage contraceptive use in this high risk patient
- However, this can conflict with a focus on providing the care that is consistent with her preferences
- Lack of desire to discuss contraception may reflect previous negative experiences with family planning providers

Matulich: *Contraception*, 2014

Samantha: Learning points

- Recognize that patients may prefer to risk pregnancy rather than use a method that is not acceptable to them

- SDM provides structure to ensure patient has verbalized her preferences and has the information and support to make decisions consistent with these preferences

Questions

Resources for Patient-Centered Counseling/SDM

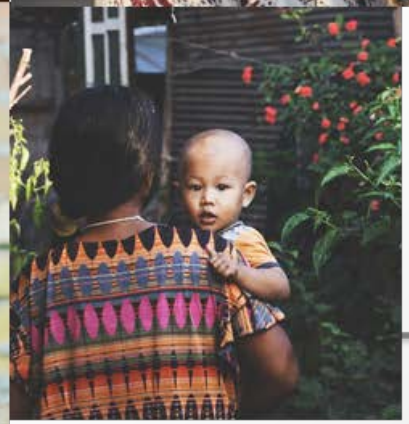
- Web-based client-centered counseling training:
  - http://fpntc.org/training-and-resources/quality-contraceptive-counseling-and-education-a-client-centered-conversation
  - http://caiglobal.co/j_cap/
- Toolkit for clinic-based training:
  - http://fpntc.org/training-and-resources/providing-quality-contraceptive-counseling-education-a-toolkit-for-training
- Birth Control Options Chart:
  - https://www.fpntc.org/resources/birth-control-methods-options-chart











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