Shared Decision Making in Contraceptive Counseling
December 15, 2015

Linda DeSantis:
First, and I'm with the California Prevention Training Center and under contract with the California Department of Health Care Services, Office of Family Planning, we're sponsoring this event. This webinar is being conducted through the computer, so there is no call-in line. The sound is coming through your computer only. So please mute your computer speakers to decrease any feedback. You will see a chat box at the lower right-hand corner of your screen. Please use the chat box to ask any questions that you may have. We'll be saving time at the end of the webinar to answer any questions. And those that do not get answered due to lack of time, we will be writing up an FAQ and having that posted. The webinar is also being recorded for later listening, for your listening pleasure later. After the webinar, you will be sent a SurveyMonkey evaluation. It will be sent to the email that you used for registration and you will be eligible for one CME or 1.2 CEs. So please look for that in your email box after 3:00 p.m. today. So, today's webinar will be delivered by Dr. Christine Dehlendorf, a family physician and faculty member at UCSF Bixby Center for Global Reproductive Health. Dr. Dehlendorf has a research program investigating women's contraceptive decision making with a focus on the needs and preferences of low-income diverse population. She also works at San Francisco General Hospital providing Primary Care and Family Planning Care. For now, I'd like to welcome Dr. Dehlendorf to begin the webinar.

Dr. Christine Dehlendorf:
Thank you so much. It's a pleasure to be here to talk about my work as well as the work of others investigating contraceptives counseling, and the role of shared decision-making specifically.

Dr. Christine Dehlendorf:
I have no disclosures. So briefly the objective of this talk are we'll review the evidence briefly for shared decision making and contraceptive counseling and describe some best practices for how to operationalize this model of counseling in your practice, We'll discuss some provider biases that can influence counseling and the role of shared decision making and overcoming them, and also briefly explore some potential barriers to shared decision making in family planning care and possible solutions to overcoming these barriers.

Dr. Christine Dehlendorf:
The outline of the talk is we're going to overview some basic approaches to how people conduct contraceptives, counseling and problematize these, I will then provide an overview of shared decision making as well as how to implement it in the practice setting. And then we'll talk briefly about a few cases that present specific challenges in the conduct of shared decision making and family planning.

Dr. Christine Dehlendorf:
So first, what evidence is there that contraceptive counseling, actually makes a difference? Well, it may sometimes seem that we have to brief a period of time, with our patients to have an impact. The fact is

that we know from evidence from the general medical literature that our relationships with patients matter. And specifically, we know that interpersonal communication affects patient satisfaction, their use of preventive care, which we know contraception qualifies as, and also medication adherence which is also obviously relevant to family planning.

Dr. Christine Dehlendorf:

With respect to contraceptive counseling specifically, we know that what methods providers talk about with their patients, and how they talk about those methods with their patients makes a difference with respect to what methods a patient will choose. In addition, we know that the quality of the family planning relationship, how comfortable and satisfied the patient is with their family planning interaction is associated with contraceptive outcomes, including women's use of contraception and their long-term satisfaction with their method. In addition to these contraceptive outcomes, it's also just true that from an ethical perspective, providing quality client centered care is the right thing to do. In addition, those of you who are Family PACT providers know that it is part of the program standards that the provision of family planning services and other reproductive health services be provided in a client centered manner.

Dr. Christine Dehlendorf:

So, what are the stages of counseling when we're providing family planning care? I tend to think of it as broken down into three different steps. One is identifying the need for contraception. And as many of you know, this is recently gotten a lot of attention around the one key question approach. How do I make sure that women for whom contraception is appropriate are identified and provided counseling? In addition, there's counseling about method options and selecting a method is essentially a contraceptive decision-making process. And then once a method is chosen, providing information about the chosen method that allows the woman to be able to use that method most effectively for her. I want to just focus on the fact that we're going to be really targeting in on the second bullet here, the decision-making process, as shared decision making suggests it's really relevant to the second bullet, but of course, I encourage you to think about the first and third bullet when you're providing things family planning care in your own practice as well.

Dr. Christine Dehlendorf:

So, what are the different ways to go about contraceptive counseling? The two most common ways are these two presented here in different ends of the spectrum. The first is consumerist counseling, which is client or patients driven. And the next is directive counseling, which is really more of a provider driven approach. And I'll go through both of these in a little bit more detail.

Dr. Christine Dehlendorf:

So, the two different flavors of consumerist counseling that we tend to see in contraception are the informed choice and the foreclosed approach. The informed choice is the one that's most talked about in the literature, especially in the international family planning literature and it's very much motivated by the goal of ensuring that patient and client autonomy is respected in the family planning encounter. And essentially this is described in different ways but how it is generally been found to be operationalize and family planning is somewhat of a menu-based approach where providers provide a list of all the options and all of the characteristics of all the options in an objective manner, and then allow the patient or the client to choose herself what method to use without any input from the provider. The foreclosed approach is a slightly different take on consumerist or client driven counseling. And that's instead of giving all this extensive information about all the different methods, rather the provider

hones in on the method, the first method that the patient mentions perhaps as wanting or a method that she has used before, and just provides information on one or two or three at the most methods and comes to a prompt conclusion or a foreclosed conclusion about what method would be best for the patient. Both of these, like I said, are really motivated by a desire to prioritize autonomy, the foreclosed approach can also be motivated by a desire to save time in the clinical encounter obviously. But it's really designed to optimize women's independence in choosing a method.

Dr. Christine Dehlendorf:

So, I've done a qualitative analysis looking at audio recordings of contraceptives counseling visits in the San Francisco Bay Area. And what we found is that in fact, consumers counseling is the most common form of counseling in our particular sample. We found that 80% of visits used foreclosed or informed choice counseling. And in accordance with this, there was very little engagement with providers, between providers and patients about the preferences that women had for methods. Rather, providers and patients actually only elicited and discussed patient preferences in 50% of the visits. And providers infrequently mentioned or elicits women's reproductive goals. So essentially, what was happening in these visits was that women were either given a variable amount of information depending on whether it was the informed choice or the foreclosed model, and then we're being left to make the decision themselves without active engagement with the provider around their preferences.

Dr. Christine Dehlendorf:

So why is this not optimal in my opinion? Well, the first from the foreclosed perspective is that it failed to ensure women are aware of it and have accurate information about method options. So, while a woman may have used the method in the past that worked for her or may have an idea of what methods she would like, that doesn't necessarily mean that she knows about what all the method options are or knows that in fact that it's the best method for her or has accurate information. The informed choice approach is problematic because of just the quantity of information that needs to go in to making a contraceptive decision with more than 10 methods of contraception being appropriate for the majority of women, and then varying on numerous different dimensions. So, providing women with just that extensive amount of information and then not providing them with any guidance about how to think about how those methods might relate to their preferences, in my opinion does not optimize the decision-making process.

Dr. Christine Dehlendorf:

So now that was consumerist counseling, so now we're going to talk a little bit about directive counseling specifically. So, what is directive counseling?

Dr. Christine Dehlendorf:

Well, directive counseling is consistent with what in reality, I think most of us know is the most common form of communication and medicine, in which the healthcare provider has an opinion on what is best for the patient and then works to get the patient to adopt that plan. And this approach to counseling is rooted in the healthcare providers preferences or opinions about what is best for the patient, or alternatively can be rooted in their assumptions about the patient's priorities, or what the patient's priorities should be. And so, in the context of contraception, this means that providers would be providing directive counseling towards specific method.

Dr. Christine Dehlendorf:

And in family planning, we're actually even though as I said consumers counseling was found to be the most common in our qualitative analysis, there is definitely a move towards more emphasis on a directive approach towards counseling. And this has been driven by our increasing interest and emphasis on long-acting reversible contraceptives methods and an enthusiasm for them in the family planning field. And therefore, this enthusiasm has spilled over into counseling specifically on the idea that we should be encouraging women to use these methods. And just to give you an example of some counseling approaches that are in line with this, with more directive approaches, you may have heard of the tiered effectiveness approach, in which methods are presented in the order of effectiveness, with the idea being to really promote an encourage consideration of IUDs, and implants specifically, and there are variable ways that tiered effectiveness is done, but at its most extreme, if the patient seems interested in IUD or implant, the counseling stops there and doesn't even talk about any of the other methods that might be a good fit for the patient. Motivational interviewing is another counseling method that has been used in the contraceptive context. This method of counseling, which was developed initially, in the context of working with patients with addictions is an approach designed to promote certain behaviors in a patient-centered way. So, while it is a patient-centered approach, it's definitely directive in that it's trying to motivate a certain course of action. And in contraception, this has been applied with the goal of encouraging women to generally to use IUDs or implants.

Dr. Christine Dehlendorf:

So why do I consider this to be problematic? Well, the first reason it's considered to be problematic is that it doesn't acknowledge the wide range of preferences that we know women have around contraceptive methods. Well, studies have shown that women highly value effectiveness in contraceptive methods. Generally, it's a neck and neck, tie between effectiveness and specific side effects in terms of what's most important to women when thinking about their contraceptive preferences. So, assuming that all women should think about effectiveness as being the preeminent consideration, and choosing a method, ignores the fact that there are these other preferences that matter to women. It also ignores the fact that women have different values around how important preventing pregnancy is to them. And for some women having an unintended pregnancy would be an event similar to having a stroke or some other severe medical occurrence. But for some women, it could be a happy accident or something that they would feel able to accommodate in their lives, even if they are not planning it at the present time. And well, this goes against many of our binary views of pregnancy planning in the family planning field. There's increasing attention to this discussion in the family planning literature that in fact, women's desires and preferences around pregnancy do not necessarily map on to this binary concept of intended versus unintended. And that this may explain some of the disconnect between our emphasis on LARC methods and the fact that some women may not find the effectiveness to be the most important thing for them. And just on a more ethical perspective, we need to consider the fact that directive counseling does not prioritize women's autonomy first and foremost, in making a decision about what contraceptive method is appropriate to them, and I think we in all aspects of reproductive health need to always hold reproductive autonomy as the utmost value. Additionally, and from a more public health perspective, we also know that being directive with patients can actually be counterproductive and have negative impacts on their contraceptive use. This data includes a study from the 1990s that showed that women who felt pressure to have the implants were more likely to discontinue it. In addition, I have data for a recent cohort study of over 340 women that showed that women who felt the provider had a preference for which method they would use, had lower satisfaction with their methods. So, whether we're thinking about it from an

ethical autonomy perspective, or from the perspective of optimizing contraceptive use, I don't think directive counseling is an optimal approach.

Dr. Christine Dehlendorf:

So, we've reviewed consumerist counseling, which has as its primary guiding principle, the idea of promoting patient autonomy. And then we have directive counseling, which has its guiding principle increasing use of highly effective methods. And on two ends of a spectrum. And what I would like us to think about is a different model that brings these two together. And gets us away from the problems associated with extreme. And this is basically designed to be a model that gets us to a quality decision that is based on patient preferences, bringing together patient autonomy with what we know about the medical evidence. And this is consistent with the approach of shared decision making, which I'm now going to talk about a little bit more.

Dr. Christine Dehlendorf:

As many of you I'm sure are aware shared decision making is a form of health communication, and that is received increasing attention in the general medical literature, with the goal of moving away from the traditional paternalistic approach. And that has been really prevalent in medical care in general. For a number of reasons, this approach to help communication is well suited to contraceptive counseling. And in fact, there's data supported use in this context, which I will discuss in a moment. Before I go into detail about this, I want to first define shared decision making. This is shared decision making is often thought of as just being synonymous with good counseling. But it's actually a very specific approach to counseling, that I'm going to describe in more detail.

Dr. Christine Dehlendorf:

So, this definition is from the informed medical decisions foundation. What it says is it is a collaborative process that allows patients and their providers to make healthcare decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences. And this process provides patients with the support they need to make the best individualized care decisions. So, the important concept here is that there's bringing together the patient's knowledge and expertise about themselves and their own preferences with the providers knowledge and expertise about the method characteristics including method effectiveness. And bringing this together to make the best decision individualized decision for that patient. Importantly, this approach to counseling shared decision making specifically is not considered necessarily to be the best approach for all healthcare decisions, rather is considered most appropriate for decisions considered preference sensitive. In other words, when there is medical evidence, supporting more than one approach, and as I've already talked about, we know that there are a range of options for contraception and women have a variety of preferences around these options, for example, how they're taken, and what side effects they have and how effective they are. And this means that the best method for an individual will depend on her preferences making it a preference sensitive decision and therefore appropriate for shared decision making. In addition, the appropriateness of this model and family planning is supported by qualitative and quantitative work, I have done to assess whether or not shared decision making is appropriate. I think we okay, if we had a technical difficulty, I think it's resolved, let us know if that's not the case.

Dr. Christine Dehlendorf:

So just to give you a sense of what the qualitative evidence is supporting the role of shared decision making in family planning, this is from a qualitative study I did a number of years ago, in which I asked

women about their preferences for contraceptives communication, family planning communication and decision making. And I didn't go in it with a desire to look at shared decision making specifically, but what came out was a very clear statement from patients, that their description of counseling was one that fit into the shared decision-making model. And this is when I asked them what their ideal approach to contraceptive decision making would be. And it's very well captured in this quote, which states I just think providers should be very informative about it and non-bias, maybe not trying to persuade them to go one way or the other but try to find out about their background a little bit and what their relationships are, and suggest what might work best for them, but ultimately leave the decision up to the patient.

Dr. Christine Dehlendorf:

Again, this interactive process in which the patient and the providers expertise are being brought together. This qualitative impression that shared decision making is appropriate has been reinforced by a quantitative study that I'm in the process of publishing, in which we followed women for six months, 342 women for six months after a family planning visit. And what we found is that women who reported experiencing shared decision making with their provider about what contraceptive method to use as compared to either provider or patient driven decision making had greater satisfaction with the decision-making process and greater satisfaction with their chosen method. So together this evidence suggests that shared decision making is both aligned with patient preferences for decision making and is associated with positive outcomes.

Dr. Christine Dehlendorf:

So, before I go on to talk about how to do shared decision making, in practice, I want to talk a moment of disparities and family planning care and how this relates to shared decision making, specifically. As I'm sure you're aware, there's a history, a complex history around contraception and specifically women of color in this country with contraceptive coercion having been happening over centuries including incidences of forced sterilization, coercive counseling and even in the past few decade’s financial incentives for implants like implant placements. And so, when we think about different approaches to contraceptive counseling, we need to consider whether and how we need to take the history into account when providing counseling.

Dr. Christine Dehlendorf:

One thing we need to be aware of is how this history may affect how our patients think about how they are counseled. Clearly, there's the potential for increased sensitivity regarding directive counseling because of issues with trust with family planning providers.

Dr. Christine Dehlendorf:

And concrete evidence of this being an issue comes from the study. It was published about 10 years ago, which found that over a third of black women that were surveyed, and this was over 500 women that were surveyed, reported that medical and public health institutions use poor and minority women as guinea pigs to try out new birth control methods. So clearly directive counseling given these concerns, directive counseling could be perceived in a very negative light. So, this also raises the question and we also think beyond just questions and trust, we also have to think whether women of color are in fact counseled differently, whether there are ripple effects from this history of contraceptive coercion in the past, in terms of how women of color are counseled. So, what we know from talking to women themselves is that women of color are more likely reporting dissatisfied with their family planning

provider, that over two thirds of black women have reports that they have received racial discrimination or been the subject of racial discrimination during family planning care. And also, that women of color in low-income women are more likely to report being pressured to use birth control and to limit their family size, than were white women and higher income women.

Dr. Christine Dehlendorf:

So, while the fact that women are reporting experiencing this is important in and of itself, it's also really important to note that there's also evidence objective evidence that this differential counseling is in fact happening. It's not just women's perception, which is would be important in and of itself regardless. So specifically, what we know is from as a study using standardized cases from the 80s, providers are more likely to agree to sterilize minority and poor women with all the other characteristics exactly the same, than white women and higher income women. And I also did a study looking specifically about whether there are disparities and counseling about the IUD, and I did this before the implant was in broad use, or I would have done it around the implant as well. And how I did this study was I created videos of standardized patients presenting for contraceptive advice. And then in a randomized trial design showed these videos to participants at national meetings of ACOG and the American Academy of Family Physician.

Dr. Christine Dehlendorf:

And these are just some examples of the still shots from the videos. These are a Latina, white and a black woman that were concerned about high SDS. And then the same patience as low SDS patients. The same women, the same actors as low SDS patients.

Dr. Christine Dehlendorf:

And what I found was that providers were more likely to recommend the IUD to low-income women of color both black and Latino women, than to low-income white women, but there was no racial ethnic difference in recommendations among high income women. So specifically, there was more likelihood for recommending a highly effective provider control method provider-controlled method to low-income women of color.

Dr. Christine Dehlendorf:

So, what does this all mean? Well, given the historical context, so we talked about around history of coercion and the fact that we know there's documented disparities and counseling that are ongoing, it is essential to ensure that providers work to overcome whatever biases may be driving this and focus on individual preferences when caring for women of color specifically, and I would add for low-income women as well. And shared decision making can be really helpful in this context, because it provides an explicit framework to focus on women's preferences and not to allow provider biases to enter into the equation. And it also is really helpful in that there maybe we may recognize, or be afraid of recognizing our own biases, and that can lead us to swing too far to the other side, and not provide any guidance or support to women in making a decision and use more of an informed choice approach, which can also be problematic for the reasons that I've stated before and that we're not providing the support that women need to make the best decision. So shared decision making can really allow us to come back to the middle and make sure that we're providing with all women with the best possible care that is focused on their individual needs and preferences.

Dr. Christine Dehlendorf:

Okay, so in summary, based on the nature of the decision data we have on women's preferences for counseling as well as in their outcome. The shared decision-making approach, which lies between the two extremes of directive counseling and consumers counseling and is explicitly grounded in women's values, is an ideal patient centered, client centered form of counseling for contraception and also has the potential to overcome healthcare disparity.

Dr. Christine Dehlendorf:

So how do we then operationalize this in practice? Well, the first aspect of shared decision making that is essential is establishing rapport. This is obviously the key aspect of client centered care in general and as a key aspect of shared decision making. But importantly, in our soon to be published data on this topic from our cohort study where we audio recorded contraceptives counseling visits, we also found that the simple act of establishing rapport is actually associated with long term contraceptive continuation. So, it has value in and of itself. The next step is to start by helping patients to identify what their preferences are, and make sure that those preferences are informed. So, this is a long conversation or not necessarily long, but this is an interactive conversation you have with patients, but in order to start it off, it can be helpful, to ask one simple question that just makes sure that patients know that their preferences are the focus of the discussion. And the question that I really encourage you to incorporate into your contraceptive counseling is to ask patients, what is important to you about your method? And I really want to emphasize that this is very different than starting by asking what method they want to start. Starting with the particular method often has the effect of closing off the conversation and making the patient feel that they should already know what they want, rather than allowing for discussion of what in fact they like or don't like in contraceptive methods. It's also important to note that patients are often not going to have an answer to this question, and that's okay. The goal of asking the question is not to assume that they already know, it's actually just to refocus them and identify for them that the goal of the conversation is to figure out what is important to them about their method. And then in fact them not knowing is an indication that this is an important conversation to have. So, whatever the answer is to this question, it then leads into a conversation in which you make sure that whatever preferences they have, or that you will elicit in the conversation are informed. And so, the things that you want to help them think about in terms of what preferences they have, are listed here on this slide. Effectiveness, frequency of using the method, different ways of taking methods, return to fertility, and then side effects in general. But we really want to focus on specific side effects and the ones that are often most important to consider are mental side effects.

Dr. Christine Dehlendorf:

So how do we go about doing this? Well, we don't want to assume women know their options. So, what you can do is provide context for the different ways that methods vary. So just to give you an example, but you can say for example, around how often you take a method, is there a method you take once a day, once a week, once a month, or even left frequently? Is that something that makes a big difference to you? So, the important thing is here is you're not mapping these characteristics onto individual methods. You're not discussing individual methods in depth you're giving women and your clients an idea for what the range of different values are for this specific method characteristic and allowing them to say whether this is something that's important to them. So, for example, you can do the same thing around menstrual side effects and talk about that there are some methods that cause your periods to be lighter, some that cause them to be less regular, and some that cause them to be heavier, is that something that's important to you? And importantly, this approach is even relevant for women to come

in and express an interest in one specific method. Because as I said before, they have an interest in a specific method that doesn't necessarily mean that they don't want to hear about other methods or that they have all their information about their options. Of course, you want to find out if they want to hear about other methods in a way that makes it clear that their autonomy is being respected. So how I usually do this is specifically ask for permission to provide information about other methods and to ask them if they want to hear about other methods. And what I found in my qualitative work is that many women actually come in feeling like they have to have a preference that the provider will feel like they're not doing their job if they don't state what they want right up front, and they don't feel like they can ask questions. So, allowing women the opportunity to hear about other methods in a way that is clearly respectful, their autonomy can actually be very client centered.

Dr. Christine Dehlendorf:

When you're helping women to generate informed preferences about different method characteristics, it's clearly important to talk about effectiveness is this is something that I said obviously is very important to women. And we also know that it's something that women also do not have good information about. Many women think that all methods for example, are relatively equally effective. And in my cohort study that I've done audio recordings contraceptive counseling visits, we also found that actually effectiveness was rarely mentioned during contraceptives counseling, and when it was mentioned, it was mentioned in very vague terms. For example, saying that IUDs are very effective without providing any more information. So, I've included on some slides, some recommendations for how to talk to women about effectiveness that can give them more concrete information. So, the recommendation in general from the literature on risk communication, is that we should use natural frequencies not percentages when talking about potential outcome. So, for example, saying less than 100 women get pregnant on the IUD, or nine in 100 women get pregnant on the pill patch and ring. It's also important when talking about these to talk about typical versus perfect use effectiveness because women may have an idea where they fall on that spectrum and that can help them to re stratify themselves using these numbers. You can also use visual aids to help people be aware and generate informed preferences around effectiveness.

Dr. Christine Dehlendorf:

So, for example, this is the WHO chart of method effectiveness. And many of you may have seen the chart from the Bixby Center that present similar information in a slightly more modern and graphically interesting way.

Dr. Christine Dehlendorf:

It's also, as I said before, side effects are an incredibly important aspect of message choice for women. It's up there with effectiveness and women often feel that providers aren't giving them adequate information about side effects. So, I think we need to be very proactive about making sure that women feel that their information needs about side effects are being addressed and being addressed respectfully. We definitely have seen in qualitative research; the patients feel that their concerns are not being respected. And also, in the audio recording this study that I keep mentioning, we have also found that oftentimes providers do not respond in a way that actually seems to take into account the patient's concerns in a serious way. And this can feel very disempowering to a patient and also cause problems with trust in the encounter. So, this is particularly concerning given that we know that counseling about side effects associated with positive contraceptive outcomes, including contraceptive satisfaction, and

contraceptives continuation. So, it's very important that we provide adequate information about side effects.

Dr. Christine Dehlendorf:

So just to give you a sense, from my qualitative work about what women said about this, this is a representative quote where one woman said, "I think that they hide the fact "of the complications or the defect, "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." So, I think it's very important that we think very proactively about how we can provide information about side effects in a way that makes sure that clients know that their concerns are being heard. Just as a couple of suggestions for how to do that.

Dr. Christine Dehlendorf:

One thing that we've definitely seen in our data is that when someone brings up a side effects that their friends or family member, there's definitely a tendency for providers to be very dismissive about that. And when that happens, in most cases, my opinion is that patients are going to believe their friends and their family members more than their provider. And so, I think we have to really actively engage and respect that this is a real lived experience that the patients are going to want to engage with and are going to give the benefit of the doubt to. So instead of dismissing this concern, I think it's helpful to say something like, that's too bad, or I'm sorry, your friend has had that experience. I haven't heard of that before. And I can tell you, it definitely doesn't happen frequently. So not discounting the friends experience, but also acknowledging the data. And then mental concerns as I mentioned before, are important ones, and it's also very important to engage with people's concerns about mental changes in a way that isn't dismissive. So typically, this often comes up around amenorrhea or in irregular bleeding. So, for example, saying "Some women don't like the idea "of not having irregular 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." So again, not discounting their preferences, but making sure they know that safety is not the reason that those preferences should exist.

Dr. Christine Dehlendorf:

So, this whole previous section has been about the process of generating informed preferences. So really helping patients before you dive into individual methods, thinking about what's important to them about their methods, again, side effects effectiveness, how often they take it, how they take it and return to fertility. And once you've kind of gotten a sense about what's most important to patients in their method, for example, is it preventing acne? Is it a lighter period? Is it dysmenorrhea? Once you've identified what's most important to them, you can then move into the process of mapping those preferences on to specific methods and helping them to think about what's the best method for them. And I call this providing the scaffolding for decision making. So given their preferences, what information do they need? And so, you go, you then start with an iterative process where you help them to think through, given that they, for example, very much want to not have acne, but they also want to use the most effective methods, those preferences aren't necessarily concordant. So, thinking through about what they prioritize given these potentially preferences and helping them think about that in a preference focused manner. And when you're doing that, it's really important to actively facilitate, giving them feedback about what methods are appropriate, given their preferences but very explicitly mapping those suggestions on the preferences instead of making suggestions about methods that are not based on the patient's preferences specifically.

Dr. Christine Dehlendorf:

To just give me an example of what this can look like. This is what facilitation can look like. You can say, "I'm 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 implants. "Can I tell you more about these methods?" Again, you're implicitly mapping the mention of those methods on to the patient's preferences, or "You mentioned is really important "to not have irregular bleeding. "The pill, patch ring and copper IUD are good options "if you want to hear more about those." And again, in some cases, patient preferences are going to be discordant, and this would be a case when you would bring that up and say, "On the other hand, "you mentioned that it is really important for you not to use hormone, so given that the copper IUD is the only one of those that fit. Would you be okay with having heavier periods" So kind of bringing those preferences together and mapping those different preferences onto methods. And this is completely over simplified, I just want to acknowledge that this is really an iterative process that is going to depend on the individual patient very much, how you go through it. And for some patients, it will be very simple and for some patients, it will take a little bit more elaboration and discussion.

Dr. Christine Dehlendorf:

So just as a summary of the steps that we've just talked about how did you share decision making? The goal is to first establish rapport for many reasons. Like I said, the next is to elicit informed patient preferences using direct questioning and in doing this, you're going to provide context to make sure that patients again are expressing their preferences based on information about the different preferences that they can have. Then you provide the scaffolding for decision making in an iterative manner, focusing on the information that is most relevant to the individual.

Dr. Christine Dehlendorf:

Okay, so what are the barriers to shared decision making, to accomplishing this in your clinical practice? Well, the first is biases towards specific methods, we all have biases towards specific methods based on medical information or our own experience or our partners experiences or our friends' experiences. So, I'm not saying we shouldn't have biases, but I think we have to be very careful about how we enact those biases in the clinical encounter. And I think being aware of them, and then making sure that we move away from those biases and focus on the patient's preferences is absolutely essential. Another thing that can be a barrier to shared decision making is just not being able to provide the whole range of contraceptive options to patients in your practice. And this can be an issue about financial coverage and can be an issue around whether or not there's anybody trained to provide this specific method. This is obviously mostly issue around long-acting reversible contraceptives methods. But I would say it's increasingly an issue around, for example, the diaphragm as well. So, I think we need obviously those of us who are Family PACT providers have limited issues with financial coverage, which is important and there's decreasing barriers with the Affordable Care Act. But that is something we still need to think about. And then making sure that we have access to the full range of methods, and professionally long-acting reversible contraceptives methods for our patients getting trained, getting our colleagues trained. Being a referral source for people who can't be trained is a very important aspect of making sure that women have the ability to actually experience shared decision making and choose a method that most can coordinate with their preferences. And then the other issue is just given the real-world health care system that we work in is obviously time constraint. I know that the description I gave of shared decision making can seem daunting, and it can seem like it can take a lot of time, I want to argue that in fact, that is not usually the case. Most of the time identifying patient preferences leaves you in a relatively, not immediately linear manner, but in a relatively straightforward path, towards a method that makes sense

for the patient and then avoid the last-minute hand on the door. "But how will this method affect my acne," type questions and get to make sure that you get a method that's a good match for a patient. But it does take longer than for example, just giving the patient the first method that she mentioned. So, it can be more time consuming in some cases. So, I think that we have to be thoughtful about how to operationalize this. One way to do this is to help patients to start the process of generating their informed preferences before they are in the room with you so that you can then have a higher level of conversation with them. So, I would encourage you to think of ways that you can incorporate material such as referring patients to Bedsider.org or other resources that they can use to be aware of their options before they come in. And I'm in the process right now of testing in a randomized trial, a decision support tool that I developed with the team at Bedsider that is actually explicitly designed to do this exact thing, basically help people think through their preferences and informed manner, and then communicate that information to providers using a printout so that they can then have a conversation about how these preferences relate to the different methods in a time efficient way. So hopefully, that will be something that will be available in the near future.

Dr. Christine Dehlendorf:

So, I'm aware that because of some technical issues, we started a bit late, I have a couple cases. Is it okay I briefly go over those?

Linda DeSantis:

Fine, I'm fine with that.

Dr. Christine Dehlendorf:

Okay, so this will be relatively brief, but I just wanted to talk about a few quick cases. So, the first one is a 21-year-old G0P0 presents the family planning, clinic requesting the contraceptive injection. She's never used contraception before, her friends use the shot, and she thinks she would like to use this method. So how would you counsel this patient?

Dr. Christine Dehlendorf:

So, this is an example of a patient who comes in with a preexisting preference, and how do you go about engaging in shared decision making in a way that is respectful of her autonomy? So, it's really important to always start by acknowledging patient preferences saying, "I hear you that's the method you say you want. If that's what you want, I will absolutely give it to you." And then it's important to like I said, to take a step back and say, "Is it okay if I just added asking, what is it about this method that you like? What's interesting to you about it?" And that will help you to kind of figure out whether her interest is based solely on the fact that it's the only method she's heard off, or whether it's because she really likes the fact that her parents don't have to know about it, or that she considers herself underweight and wants to gain weight or whatever the reason might be, you can then unpack that a little and help understand what her preferences are, and also what her maybe information gaps might be. And then, like I said before, in these patients who come in with a preference asking for permission to discuss other methods of contraception that might align with those preferences can help ensure that she's able to make the best quality decision possible for her while also feeling that her autonomy is being respected.

Dr. Christine Dehlendorf:

Okay, so the second case is an adolescent comes in the office for an annual well-visit, she's sexually active and currently using condoms and withdrawal for contraception. She's satisfied with this method of contraception; how would you counsel this patient? So, I wanted to include this case, because I think that it's really clear for all of us that there are certain patients that trigger us, often it's the adolescent. Often, it's a patient who has had multiple unplanned pregnancies in the past, or those choosing a method that we don't consider to be optimal. And this patient incorporates a few those examples. And so those patients can often be hard for us to counsel in a way that is completely focused on patient preferences.

Dr. Christine Dehlendorf:

So, the things that I would emphasize in this is that establishing a rapport is the most important first step. Regardless, whenever I feel myself getting triggered in any of my encounters, I just always step back and realize the most important thing is that interpersonal relationship with the patient. And in this particular case, around adolescence, specifically, I just want to acknowledge that there's more tendency to be directive with adolescence around a range of issues, including contraception, but reproductive autonomy doesn't have an age cutoff. And so, I think it's really important that we remember that even in these cases, we need to really prioritize autonomy. And in addition, providers being directive with adolescents can even be more problematic because there's definitely developmental issues and responses there. So, we really have to think remember that our goal is to establish a positive long term therapeutic relationship with these clients. And then eliciting the patient's preferences surrounding method characteristics, including effectiveness can help you figure out if whether or not the choice of condoms or withdrawal is in fact, a preference important decision for her. And if it's not, then you can help you counsel her about other methods that may align better with her preferences, or if it is, turns out to be aligned with her preferences, then it allows you to identify that and to feel comfortable that she has made an informed preference concordant decision. So again, the patients that can be potentially challenging for us, refocusing on patient preferences, and making sure the patient is making an informed decision can be very valuable. And then of course, there are standard things we should do with all of our patients, including reducing risk of STI and screening for reproductive coercion.

Dr. Christine Dehlendorf:

And then the last case I'll just talk about briefly is a woman who comes in wanting her IUD removed, because she's unsure she wants to have kids, but she wants to have that option. So how would you counsel that patient? I'll just briefly say we have a tendency as providers and there's been a couple studies recently that have come out about this showing that providers often present barriers to patients who want to have their IUDs removed. And this is obviously problematic on many levels. But I think it's imperative for us as a family planning community, that we make it clear that patients have the ability to have their implant or IUD removed at whatever point they decide that they don't want it anymore without having to justify their reasoning. That being said, I think if you come at it from a patient preference perspective, and you first assure the patient that you will, of course remove it at their request, but then again, ask for permission to talk about why they want it removed, you can make sure that their decision to have it removed is based on an informed set of preferences rather than

misinformation, for example, that there's a long time before return to fertility after getting an IUD removed. So now I will take any questions.

Linda DeSantis:

We have two questions. And they are up there still on the on the board. But the first one was from Adam, "Some explanation about circumstances in reporting counseling services along with the E&M codes reporting on the same day."

Dr. Christine Dehlendorf:

So, I will refer that OFP because that is not my area.

Linda DeSantis:

Okay. And James, I believe that you're on the line. Are you able to--

James from the Office of Family Planning:

Yes. Yes, we can address that in the written Q&As if Adam and I think it was also maybe William had a similar question. In the meantime, they could certainly contact the financial intermediary Xerox at the 800-541-5555 number and get a more immediate guidance on that. That some we will include that in the written Q&A.

Linda DeSantis:

Okay, great. Thank you, then second question that we have, it's from Edna, "Can you change one contraception "from another contraception? If so, how often?

Dr. Christine Dehlendorf:

So, clients can definitely change contraceptive methods whenever they feel it is appropriate. There are of course, some methods for example, Depo, that last are in the body for quite some time, and they're going to be individual considerations. But usually there's no problem even with Depo with overlapping methods. So, I think that the answer would be whenever a woman decides a different method is better for her. And I think the goal with your decision making is to find a method that is most aligned with a woman's preferences so that it is both maximizes her reproductive wellbeing, but also is a method that she will be able to continue over time because it is a good fit for her. But that by no means does suggest that her preferences can't change or her goals can't change and she might want to change methods at which I absolutely encourage everyone providing contraceptive counseling to tell patients that if their method isn't a good fit for them, that they can and should come back and talk to the provider about that, because I think oftentimes women feel that they are, quote, unquote, failure if their method is not a good fit for them, and they feel like they shouldn't come back and admit that as opposed to feeling welcome to come back, and to think of it as an opportunity to find a better method as opposed to a failure.

Linda DeSantis:

Great. And our next question is, "How do you answer patient concerns about BCM horror stories especially around IUDs and ensure?

Dr. Christine Dehlendorf:

Yes, this is incredibly challenging. And I think it depends on what kind of horror stories you're talking about. I think that when you're talking about something that someone might have heard from their social community directly, I think it's really important to be incredibly careful not to be dismissive in any way, shape, or form. And you can talk about data and talk about, you can and should talk about data, but do so in a way that doesn't imply that any information that a patient might have gotten from someone else's lived experience is invalid, because I think that invalidates us as providers, when we don't take into account the real life lived experience out in the world. That said, I think it's a slightly different when we're talking, for example, about the late-night trial lawyers, commercials, etc., that they might hear, I think we can problematize that and suggest to patients that the motivations of those types of commercials might not be actually the best interest of women's health. So, I think you have to target your response to the specific situation, but I think feeling comfortable using data but in a way that is respectful is really important.

Linda DeSantis:

Great, it seemed that Adam had raised his hand and we believe that he was asking a similar question that William asked, and that James from the Office of Family Planning had responded would be answered in the FAQ post webinar. So hopefully that is what your hand was raised about Adam, and that we'll follow up with that, when we come up with the FAQ. Looks like Veronica is typing possibly a question for us. So, if there are other questions please feel free to type them in the chat box now. Veronica's asking will you let us know when the PowerPoint will be ready to print and the audio for us to listen? Yes, we will. We will be sending out emails with containing the link and the PDF of the slides. So, we're at our time, we don't have any additional questions. I want to remind folks that are on the line. You will be receiving an email with a SurveyMonkey evaluation, and we'll provide instructions on getting your CME or CEU. And so, at this time, I would like to thank Dr. Dehlondorf for this very informative presentation. And thank you all for attending and for your patience with some of our technical glitches. The audio and PDF slides will be available shortly. Thanks all and good afternoon.