

The history of tiered-effectiveness contraceptive counseling and the importance of patient-centered family planning care



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A main strategy that has emerged in the United States for reducing the proportion of pregnancies that are unintended is to increase the use of long-acting reversible contraceptives (LARC) because of their high efficacy.¹ In the past decade, policies and programs such as the Affordable Care Act contraceptive mandate and both privately and publicly funded state-based programs have made considerable progress in eliminating barriers to contraception, and to LARC in particular. One such effort is the adoption of the tiered-effectiveness contraceptive counseling model, in which patients receive information about the most effective methods of contraception first. This model was developed to ensure that both providers and patients have accurate information about LARC. Studies have shown that tiered-effectiveness counseling is associated with an increase in patient knowledge about contraception² and LARC use.¹

Tiered-effectiveness contraceptive counseling is now recommended by several professional organizations.³ However, clinicians, researchers, and advocates have raised concerns about whether LARC promotion, and tiered effectiveness counseling in particular,

Public health workers, clinicians, and researchers have tried to increase long-acting reversible contraceptive (LARC) use by changing contraceptive counseling between patients and providers. Several major health organizations now recommend tiered-effectiveness counseling, in which the most effective methods are explained first so that patients can use information about the relative efficacy of contraceptive methods to make an informed choice. Some scholars and practitioners have raised concerns that, given histories of inequitable treatment and coercion in reproductive health care, tiered-effectiveness counseling may undermine patient autonomy and choice. This Clinical Opinion examines the development of tiered-effectiveness contraceptive counseling, how its rise mirrored the focus on promoting LARC to decrease the unintended pregnancy rate, and key considerations and the potential conflicts of a LARC-first model with patient-centered care. Finally, we discuss how reproductive justice and shared decision making can guide efforts to provide patient-centered contraceptive care.

Key words: choice, contraception, coercion, implant, IUD, LARC, reproductive justice, shared decision making, tiered counseling

conflict with the central goal of family planning care: to ensure that patients have the resources and information they need to decide whether, when, and how to have children. To understand this tension, we review the history of tiered-effectiveness counseling and how reproductive justice and patient-centered models of care are aligned with the goals of contraceptive counseling.

A brief recent history of contraceptive counseling

The theory around using LARC to decrease unintended pregnancy rates stemmed from evidence that LARC use was overall low in the general population and that, despite patients valuing efficacy in their contraceptive method, many barriers prevented their use. The Mirena (Bayer, Whippany NJ) and Paragard (Copper Surgical, Trumbull, CT) intrauterine devices (IUDs) and contraceptive implant Implanon (now Nexplanon, Merck Sharp & Dohme B.V., Kenilworth, NJ) were available in the United States in the early 2000s,

but total use comprised only about 2.4% of all women using contraception in 2002.^{4,5} In the early 2000s, research found that misinformation among both providers and contraceptive users about associated risks, upfront cost of devices, lack of provider training, and backlash from the failures of the Dalkon Shield (A.H. Robins Company, Richmond, VA) likely contributed to the low prevalence of LARC.^{6,7} These articles described the benefits for individual patients, including low failure rates and cost-effectiveness.^{6,7} Several studies of women's preferences in birth control characteristics found that efficacy is highly valued, with some studies demonstrating that it is the most important part of contraception to women.^{8,9} Articles increasingly motivated their work by proposing the idea that increasing LARC use could have a meaningful effect on lowering the unintended pregnancy rate and abortion rate.⁷

The renewed enthusiasm for LARC gave rise to a shift from general contraceptive education and counseling

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to using a tiered-effectiveness approach.^{10–12} This method of counseling focuses on efficacy of contraceptive methods, with the most effective methods discussed first, followed by less effective methods. In visual aids using this counseling method, LARC methods are placed at the top of the chart and less effective contraceptives are listed further down,¹³ thereby prioritizing LARC methods. The purpose of tiered-effectiveness contraceptive counseling is to allow patients to compare relative efficacy of methods and to use this information to make an informed choice about their birth control. As Higgins noted in 2014, “the field has witnessed a distinct shift from options-based counseling, in which a wide array of contraceptive methods are presented to potential contraception users, to directive and/or first-line counseling in which one or two LARC methods are recommended over all others.”¹⁴

The tiered-effectiveness model has been increasingly studied and recommended over the past 15 years. The first study on tiered-effectiveness counseling was in 2005. To address the gap between patients’ valuing method efficacy and low LARC use, the investigators compared 3 contraception decision tools with varying emphases on efficacy, including one tool that is the predecessor to the tiered-effectiveness charts used today.² The study found that although all 3 charts improved patients’ knowledge about contraceptives, the tiered-effectiveness chart was easiest to understand.² The World Health Organization (WHO) Expert Working Group Meeting on the Global Handbook for Family Planning Providers relied on this study’s results in their endorsement of the tiered-effectiveness chart for contraceptive decision making.² The first version of the Global Handbook was published in early 2007, and encouraged physicians to incorporate this model when counseling patients about contraceptive options.^{2,15}

The greatest test of this tiered-effectiveness contraceptive counseling came from the Contraceptive CHOICE Project, which aimed to “provide no-cost contraception to a large number of

women...and to promote the use of long-acting reversible contraception” in hopes to reduce the unintended pregnancy rates in St. Louis.¹⁶ Although the Steiner study and the WHO Global Handbook helped introduce the tiered-effectiveness model to clinicians, the Contraceptive CHOICE project provided the first data on its use in a large sample of contraceptive users.^{1,16} The Contraceptive CHOICE Project studied the effects of removing barriers to patients’ LARC use that had been identified in previous studies: in particular, cost, provider bias, provider training, facility availability, and finally, patient information.¹⁶ The latter was addressed using tiered-effectiveness counseling for all study participants.

The Contraceptive CHOICE Project’s methods describe using the GATHER process (Greet, Ask, Tell, Help, Explain, and Return) to model their counseling, which uses a “client-centered process focused on the woman, her expressed needs, situation, problems, issues and concerns.”¹² The way in which they described the process, however, was more streamlined. When a patient presented for contraceptive counseling, they were read a script by the counselor that outlined each type of contraception according to the tiered-effectiveness contraceptive model.¹⁷ Methods were explained in detail starting with LARC, with the diaphragm and natural family planning discussed only if the patient brought them up.^{12,17,18} After the script, patients were asked a series of questions such as, “What questions do you have about any of these methods?” or “What birth control method sounds like a good choice for you?”^{12,17,18} This model of counseling focuses more on efficacy and other facts about contraception instead of asking about patients’ preferences and providing individualizing counseling.¹⁹ Dehlendorf, Krajweski, and Borrero describe this as using “task-oriented communication” to provide information, rather than “relational communication.”¹⁹ They note, in their best practices recommendations for counseling, that both are needed to achieve a patient-centered contraceptive counseling experience.¹⁹

The first study published from the Contraceptive CHOICE Project showed an unprecedented result: 67% of study participants chose a LARC, compared to the 2.4% national average.^{1,16} The study raised awareness, discussion, and contributed to the adoption of tiered-effectiveness contraceptive counseling among US-based providers.^{1,3} Other interventions have modeled aspects of the Contraceptive CHOICE Project, including-tiered effectiveness. Perhaps the most famous was the foundation-funded effort to provide LARC to low-income teens in Colorado, which sought to “make LARC placement the default clinic visit outcome”²⁰ and was found to have led to a modest decrease in the teen birth rate.²¹

The Contraceptive CHOICE Project led to the adoption of tiered-effectiveness counseling recommendations among major professional organizations, since 2012, from the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and American College of Obstetricians and Gynecologists (ACOG).^{2,3,15,22,23} ACOG’s most recent guidance on contraceptive counseling recommends that “LARC methods should be first-line recommendations for all women and adolescents.”²² Likewise, the American Academy of Pediatrics’ (AAP) most recent guidance on contraceptive care for adolescents states that “pediatricians are encouraged to counsel adolescents... discussing the most effective contraceptive methods first.”²⁴ These recommendations underscore that patient choice and preference is a priority, but say little about how to square that with a LARC-first approach, especially when a patient does not want a LARC or wants a LARC removed. Our concern is that even though the centrality of patient preferences and the call to encourage LARC use are both found in the same guidelines and committee recommendations, clinicians are left without guidance when patient choice and LARC-first recommendations come into conflict.

Where are we now?

Access and use of LARC has expanded considerably in the United States since 2002. The proportion of women using

contraception who use a LARC method more than doubled from 2008 to 2014, and this is reflected among women in all age and race/ethnicity groups.²⁵ The Affordable Care Act has decreased out-of-pocket costs for contraception.²⁶ Some state Medicaid programs have increased reimbursement for LARCs and moved to cover postpartum LARC insertion.²⁷ Some communities have had privately funded interventions to provide free LARC.²⁸ As well as clinical training and billing streamlining.²⁹ In the same time period, many training and education initiatives have been started to train obstetrician–gynecologist providers and family medicine physicians on how to place these devices.

This current landscape focused on increasing LARC access and use raises a question of whether the tiered-effectiveness counseling approach is consonant or in conflict with contraceptive counseling guidelines that state that patients may choose to use the contraceptive method that they prefer. It also raises a broader question: namely, if efficacy is not the right focus, what counseling approaches should clinicians use to help patients prevent and plan for pregnancy, including ensuring the ability to choose their preferred method of contraceptive without barriers, judgment, or coercion?

Indeed, other models of contraceptive counseling have emerged since tiered-effectiveness, some that center patient preferences in guiding the clinical encounter before efficacy, and others that focus on effecting behavior change. One example is reproductive life plan screening using the “One Key Question” (OKQ).^{30,31} OKQ encourages providers to ask reproductive-aged women if they want to become pregnant in the next year. This screening question helps to triage patients into pre-pregnancy planning, such as starting prenatal vitamins, or discussing contraception if they are not interested in pregnancy at this time.^{30,31} OKQ is now required by some departments of health, and has been incorporated into several electronic health records.³⁰ Another model is motivational interviewing, in which, similar to other health interventions

such as smoking cessation, patients are encouraged to initiate a behavior change—in this case, to move toward using contraception.³² Finally, some have argued for a shared decision-making model in which clinicians focus on “building partnerships with patients, where patients function as experts on their preferences and needs and providers function as experts on the medical evidence.”^{31,33} Indeed, Kowal et al included an entire chapter on patient-centered contraception counseling, whereas the previous version only had separate treatments of considerations of safety, efficacy, and “personal considerations.”^{34,35}

Potential conflict between tiered-effectiveness counseling and patient preferences

There are several concerns that have been raised about the “LARC first” approach exemplified by tiered-effectiveness. One is that the provider-controlled nature of LARC means that they are inherently more capable of being used coercively compared to methods that patients can stop using on their own. Another is that the ways in which providers are educated to provide and to promote LARC may lead them to prioritize their preferences for what they think patients should use over the preferences of patients themselves.^{14,36} This is reflected in training and practice, in which clinicians are taught that their job is to “get” patients to use a LARC and do not have good guidance on patient-centered approaches on how to honor requests for removal.^{36,37} That LARC are recommended “first-line” methods generates a provider bias that LARC are the “best” contraception, and the belief that patients do not choose LARC primarily because they are not educated enough about them or must justify their reasons for not doing so.^{37,38} In addition, rhetoric regarding the use of the clinical encounter to reduce the unintended pregnancy rate on a population level is a misapplication of a population-level indicator. This rhetoric can cause providers to believe that whenever a patient does not choose a LARC, the provider’s clinical goals are in direct conflict with

the goals of the family planning clinical encounter, which is to ensure that the patient can use the birth control method that they feel is best for them. Moreover, racism and sexism that shape the broader society necessarily create implicit biases within providers and thereby influence the clinical encounter. Therefore, overly directly or coercive contexts for the use of LARC may be more likely among low-income patients, young patients, patients of color, and patients with certain comorbidities such as substance use disorders.³⁹

These concerns are justified, since physician bias towards LARC can be perceived by patients as a form of contraceptive coercion.^{40–42} While patients may value efficacy, they also value other features of contraceptive methods and there is no method that has all of the features that are important to them.⁴³ Patients seeking contraceptives must weigh their options against their individual preferences, values, needs, and priorities. A tiered-effectiveness approach alone cannot provide space and guidance for patients to do that. While some patients may express frustration around this bias, others feel guilt and shame in their choices which further perpetuates issues around contraception choice, parenthood, and abortion stigma.^{10,40,41,44}

There is an opportunity to use reproductive justice within reproductive healthcare field, and specifically when counseling patients on contraceptive options, to develop practices that do not risk undermining patients’ autonomy. Originally coined by a collective of Black women, reproductive justice is the human right to have a child, not to have a child, and to parent in a safe, sustainable environment to allow families to thrive.⁴⁵ The reproductive justice framework explicitly recognizes historic and current forms of racialized and gendered reproductive oppression, and therefore provides a lens for understanding the way in which targeting interventions to promote LARC to groups that are systematically discriminated against, such as by race/ethnicity, immigration status, wealth, health status, or substance use disorder, may perpetuate bias and result in harm.^{14,46}

Some may argue that a more pressing concern is that many barriers still exist between a patient and her preferred contraceptive method, especially LARC. Although there is still progress to be made in ensuring that patients have the information, resources, and services that they need to use their preferred method of contraception,^{39,47} this can coexist with coercive clinical encounters and in fact may exacerbate them. We must create training and practice guidelines and advocate for policies that address both. To mitigate the conflict between a patient's autonomous choice and provider bias, we must recognize that our goals must be our patients' goals. The tiered-effectiveness approach was developed in response to a specific contraceptive landscape in the early 2000's, when LARC were not widely available. In maintaining the tiered-effectiveness approach as a standard of care, we are deciding what all patients need hear to make that choice. This can lead to patients feeling overly directed or coerced into choosing a certain method, cause dissatisfaction with their care and their method, and create skepticism around providers' intentions.^{40–42} These potential pitfalls³¹ are not random. When providers and patients' preferences align, a tiered-effectiveness approach may not unduly pressure a patient or miss the patient's needs regarding contraception. However, when patients have differing preferences from their providers' or circumstances that providers believe should influence contraceptive choice, providers who think that LARC is the "best" method may believe that patients are not making decisions with which they agree.³⁶ A patient-centered approach such as shared decision-making can help providers be self-aware not to prioritize their preferences over patients', particularly in these circumstances. Patient-centered counseling "aims to provide education to patients that integrates evidence-based recommendations with patient preferences, recognizing that patients' individual values and preferences should be an integral factor in decisions made about their health care"³¹ and ensures that "patients function as experts on their

preferences and needs and providers function as experts on the medical evidence."³¹

As efforts continue to improve access to LARC, providers and contraceptive counselors should use contraceptive counseling approaches that center around the goal of ensuring that patients' preferences are met regarding contraceptive choices. The individual clinical encounter should not be considered a mechanism by which to "reduce the unintended pregnancy rate," because it is not patients' responsibility to choose a LARC or any method in service of moving a national level indicator; rather, family planning care exists to ensure that all people can plan for and prevent pregnancies, including using contraceptives that meet their lifestyle, as well as sexual health and needs. Efficacy is an important factor in many patients' choices, but it is not the only, or even the primary, factor for all patients; even patients who value efficacy may still not choose to use a LARC for other reasons.⁴⁸ Any family planning program should "put the priorities, needs and preferences of individual women—not the promotion of specific technologies—first."¹¹

Recommendations for patient-centered counseling:

- Before providing information on contraceptive options, it is important to determine what values and preferences the patient has regarding contraception and, more broadly, the patient's reproductive life goals.
- Providers must find a balance between correcting misinformation about contraceptives and dismissing negative experiences around prior use.
- Patients are allowed to have conflicting views between their pregnancy intention and use of contraception. Pregnancy is not always a negative outcome for those experiencing an unplanned pregnancy, and pregnancy ambivalence can be factored into contraceptive counseling.
- Providers in programs that help improve access to LARC devices should recognize the coercive

situations that they may create. For example, having access to a free LARC device versus paying per pill pack per year creates a non-choice for those in lower socioeconomic groups.

- Programs that target improvement in access to LARC in certain populations such as substance use disorder patients or prisoners can perpetuate judgments regarding who should be parents.
- Screening for contraceptive use with programs like One Key Question help to start the conversation, but should be used to initiate a conversation about deeper values around reproductive goals.
- It is important for providers to use tools such as Implicit Bias Training to learn about their own biases and how these may factor into contraceptive counseling.
- Providers should incorporate reproductive justice tenets into their provision of healthcare and use shared decision making as a model for counseling versus one-fits-all counseling scripts. ■

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