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Estimated the Differences in Adjusted Rates of Non-Indicated Pelvic Examination by Provider Specialty

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Description

Survey research suggests that clinicians frequently perform pelvic examinations prior to prescribing contraceptives, despite evidence that mandatory pelvic examinations discourage the use of contraceptives and are not clinically necessary. The prevalence of non-indicated pelvic exams during contraceptive encounters is estimated in this study, along with variations in prevalence based on provider specialty. From 2007 to 2017, we identified contraceptive encounters among females aged 15 to 49 without concurrent indication for pelvic examination using a national sample of commercial claims data. The non-indicated exam rate was first calculated by provider specialty and patient age. We estimated the differences in adjusted rates of non-indicated pelvic examination by provider specialty using data from 2017 and linear probability models with fixed effects for metropolitan statistical areas. We used all years of data and interacted specialty with year to evaluate trends by provider specialty. From 2007 to 2017, more contraceptive visits included pelvic examinations. Over half of all contraceptive encounters were overseen by obstetricians and gynecologists, who performed the most non-indicated pelvic exams and saw increases across all provider specialties. This study provides real-world evidence that patients frequently undergo a low-value, invasive examination when receiving contraceptive care and that pelvic exams are increasingly performed during these encounters. To change clinical practice, continuing education, reforming reimbursement and more evidence on the harms of pelvic exams that are not indicated will be required. Non-White women with lower incomes and education have historically been more likely to use permanent contraception. We investigate the shifting sociodemographic patterns of permanent contraception and LARC in light of the growing popularity of LARC. According to the most recent NSFG survey, LARC use is comparable to that of permanent contraception, but there are still socioeconomic differences.

Clinical Practice of Female Permanent Contraception

Identifying and removing structural obstacles to women's access to the most effective contraceptives requires ongoing work. To get a better understanding of how reimbursement policies are implemented, we looked at the Medicaid websites of the states and spoke with state employees. We tried to get information about the policy and instructions for doctors from all 50 Medicaid office websites. In order to conduct semi-structured qualitative interviews, we invited staff members from each of the fifty Medicaid director's offices in each state. For the purpose of analysis, we were able to obtain data from the websites of 48 states, conducted 15 telephone interviews, and received 4 written responses from Medicaid employees in those states. When compared to the federal policy, state policies varied greatly in terms of the degree of online instruction available to clinicians, the number of content-related and logistical changes made, the types of procedures included, the types of corrections permitted, the review process, the reasons for and ramifications of denial, and the date of the last policy revision. State Medicaid offices need to be more open and provide more information, and the Medicaid policy needs to be changed to take into account the current clinical practice of female permanent contraception. To ensure that their clinical practice is accurate and reimbursable, clinicians should communicate with Medicaid employees in their state to clarify important policy details and gain a better understanding of their state's review process and ramifications. It is essential to ensure that physicians are fairly compensated for their work and that female permanent contraception remains an accessible method of contraception for women by achieving greater consistency between states in terms of Medicaid policy and implementation. In November 2019, we attempted to conduct a telephone survey with representatives of all 60 known Swedish abortion clinics, including public hospitals and private clinics. We inquired about the characteristics of the clinic, the procedures followed by the clinic regarding the early insertion of IUDs and implants, adherence to the guidelines, and, where applicable, perceived reasons for nonadherence. At the time of administration of mifepristone, implant placement is recommended, and intrauterine devices (IUDs) are inserted within seven days of misoprostol treatment. Our goal was to identify and describe the obstacles that abortion researchers in American academic medical centers face. We specifically focused on institutional review board (IRB) or research ethics committee interpretations of Subpart B of the 2001 Code of Federal Regulations, which states that researchers cannot participate in decisions regarding

the timing, method, or procedures used to terminate a pregnancy. These interpretations impose regulatory restrictions on abortion research. We set out to document the experiences of investigators in obtaining approval from their IRBs and to identify obstacles that prevent investigators from producing evidence regarding abortion care. Participants in the interview said that the way their institutions' institutional review boards applied federal regulations to abortion research varied significantly. The regulations made it difficult to conduct abortion research at a number of institutions and discouraged some researchers from ever doing so.

Three Phases of Comprised Data Collection

At other institutions, interviewees did not encounter significant obstacles related to their IRB's interpretation of Subpart B. Numerous interviewees suggested overcoming obstacles and carrying out successful abortion research by developing and maintaining positive professional relationships with IRB members. This exploratory study found obstacles that could impede the production of evidence regarding abortion care at some academic institutions. These obstacles can serve as a guide for future efforts to overcome obstacles in abortion research. The preference for medication abortion may be motivated by stigma and misinformation regarding pregnancy, such as health and safety myths propagated by state-mandated abortion counseling. Obstacles to abortion access may make it difficult for individuals to obtain their preferred method. People may be able to obtain their preferred method of abortion more easily if obstacles to clinic access are removed. 100 women of reproductive age who identify as women were the subjects of an exploratory and prospective study. We instructed participants to investigate either the risk of infertility following surgical abortion or CD or the safety of CD or surgical abortion. Three phases comprised our data collection: baseline survey, a survey after the search, and a survey after the search. Using bivariate tests, we looked at the responses of participants before and after the survey, as well as changes within subjects. Based on expert ratings of site content based on trustworthiness and bias, we evaluated the websites they visited. doctors, such as gynecologists, obstetricians, family doctors, and emergency room doctors; nurses, including nurse practitioners and registered nurses; midwives, including clinical midwives and trainee midwives; trainees in medicine, such as residents, fellows, and medical students; and all other female-focused medical professionals. In the context of recent statements on the utility of pelvic examination published by national task forces, this publication provides clarification regarding indications for pelvic examination. Our goal is to minimize the time it takes to diagnose a disease that can be treated for women who have clinical indications for examination.