Advisory Board

5 hard truths for provider business in a post-*Roe* America

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On June 24, 2022, the Supreme Court issued its ruling in *Dobbs v. Jackson Women's Health Organization*, overturning *Roe v. Wade* and throwing the issue of abortion access and its legality to state-level jurisdiction. Thirteen states had "trigger laws" set to take effect if *Roe* was overturned, and even more new laws related to abortion access are making their way through state legislatures.

Unwinding a half-century-old framework for medical practice will have implications for every corner of the health care industry. Because providers have some of the largest and most immediate questions, this report focuses on the impact for hospitals, health systems, and physician groups and their leaders.

Many providers have not felt pressure to declare a public position on abortion – either politically or through offered services–because in many markets alternatives were available. Most large health care institutions left elective abortion care to independent abortion care providers, who deliver the vast majority of abortions in the United States. The temptation to continue to fly under the radar is understandable, especially when it may feel like it is a no-win proposition to engage in a heated political environment. However, with *Roe* eliminated, the real-world consequences of policy change on clinical workflows and employee engagement cannot be avoided.

We've outlined five hard truths about restricted abortion access and how it will impact provider businesses. Though some of the recommendations below may apply to other organizations, we plan to publish more in-depth work on how this will specifically impact other sectors of health care.

In this report, we share the consequences of inaction, offer action steps to mitigate those business risks, and share implementation guidance to help leaders navigate an uncertain moment for the health care industry.

5 hard truths for provider business in a post-*Roe* America

Hard truth 1: You need to plan for more than just your balance sheet.

- Action step: Watch for shifts in volume, payer, and case mix, but focus efforts on the hidden costs that present more serious near-term business risk.

Hard truth 2: Your workforce and patients will demand clarity on how you're responding (whether you want to share it or not).

- Action step: Provide immediate emotional support to your workforce.
- Action step: Create a single source of truth for patients and consumers.

Hard truth 3: You're facing legal uncertainty—and it's going to impact your staff in more ways than one.

- Action step: Constantly ensure the workforce is aware of new (and changing) legal realities.

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- Action step: Adapt clinical and operational pathways in accordance with new policies.

Hard truth 4: You need to update your workforce policies—and they'll likely need to keep evolving.

- Action step: Craft a benefits policy to address the geographic implications of *Dobbs v. Jackson* on each facility in a way that reflects your mission and keeps you competitive as an employer.
- Action step: Address the implications of restricted abortion into professional development strategy.

Hard truth 5: You're going to face growing demand for women's health care—while OB economics deteriorate.

- Action step: Critically evaluate obstetrics unit finances and proactively plan for gap-filling services.
- Action step: Support holistic women's health across all service lines.
- Action step: Address the root causes of maternal health inequities.

Hard truth 1: You need to plan for more than just your balance sheet.

Action step: Watch for shifts in volume, payer, and case mix, but focus efforts on the hidden costs that present more serious near-term business risk.

This industry knows all too well that business impact is much more than volumes, cost centers, and revenue streams. The Covid-19 crisis has shown what the load of constantly shifting strategy does to weary executive teams, the toll crisis after crisis has on our workforce, and how innovative solutions fall to the back burner as leaders pivot to put out the next fire.

That said, volumes forecasting is the backbone of provider financial planning. Many leaders we have spoken with since the draft *Dobbs* ruling was leaked expect an increase in pregnancy care volumes. Early Advisory Board analysis shows that despite a wide range of business and operational challenges in a post-*Roe* world, abortion restrictions are unlikely to change provider volumes enough to significantly impact overall finances. That's because the proportion of pregnancies that end in abortions is small—only about 15% of pregnancies today—and an even smaller share of those will result in an increase in births (and thus, labor and delivery volumes). Given the absence of a federal abortion ban, some women in states where abortion is now more restricted will access a desired abortion out of state or, as has always been the case, through other means.

Similarly, OB units will likely see greater complexity (and costs) from maternal and fetal health complications, but the overall impact will be marginal, as most abortions are not conducted on the basis of maternal and fetal health. If those are the patients who would also have more complicated pregnancies, it's unlikely to be a large enough population to change the average complexity of a hospital's obstetrics unit in the near or medium term.

While the overall volume impact may be small, for most providers the level of distraction and confusion could be disproportionately high. It will be important to get ahead of any downstream impact on staffing, operations, or larger population health and equity efforts. We recommend that providers measure volume, payer, and case mix shift with an eye to both internal and external reporting that may not previously have been expected.

Furthermore, in this environment even a single clinical event—particularly one with patient safety or legal ramifications—could have immense potential for operational and legal complexity, administrative burden, moral exhaustion among staff, and serious

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reputational risk for the institution. These hidden costs represent the bulk of the business risk for providers.

Implementation recommendations for leaders:

- Monitor the ED for patients presenting with symptoms of pregnancy complications.
- Track shifts in obstetrics volumes, complications, and payer mix at the organizational and facility level. Specific data cuts may help understand how shifts impact the operations in different specialties, care team members, or at specific sites—particularly in rural areas.
- Use near-term leading indicators to track longer-term impacts for health disparities, at a minimum cutting the data by race, ethnicity, and socioeconomic status.
- These data should be frequently reviewed with elevated attention by senior leadership and other stakeholders to expedite any necessary resource reallocation or operational adjustment.
- Keep corporate communications and public relations in the loop on data reporting and ensure that they have sufficient familiarity with the relevant operations to put those trends in context when describing the impact of new laws on the organization and on patients.

Hard truth 2: Your workforce and patients will demand clarity on how you're responding (whether you want to share it or not).

Action step: Provide immediate emotional support to your workforce.

Employees' emotional responses to the ruling could have significant negative impacts on staff morale productivity, absenteeism, and presenteeism—all of which will be harmful to your bottom line if left unchecked. Imagine colleagues of yours in a variety of roles and levels, some of whom intensely disagree with the *Dobbs* ruling and some of whom intensely agree with it. How can they know that their employer is sensitive to how this affects their work, their benefits, and their sense of community in the workplace?

We're already in a workforce crisis that's only been intensified by Covid-19. Staff, especially those in clinical roles, are losing confidence that health care organizations are committed to worker wellbeing. For many employees, that gap between their organization's stated values and lived values has driven them to leave their employers, and in some cases the health care field entirely. For others who have stayed, an institutional response to the *Dobbs* ruling characterized by silence, denial, or bureaucratese could easily push them over the line to seek a new employer whose organizational commitments more clearly match their personal beliefs on abortion or other core values.

Staff who directly touch abortion care or maternal health generally merit a focused approach to their engagement. In states where abortion remains available, your staff providing care will appreciate acknowledgement that their work is valued. And, the acknowledgement that their job is likely to get harder as they deal with travelers from states where abortion has been newly restricted. Even in states where abortion is banned or severely restricted, patients will seek access to care and staff will have to navigate new levels of logistical and emotional complexity. In emergency situations, the decision to provide certain care or not will have a huge emotional toll—not to mention clinical confusion and new manifestations of legal risk.

It is vital to check on your staff wellbeing early and often. This is especially important for staff most likely to encounter the elimination of *Roe* in their daily work. This isn't limited

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to physicians, nurses, and care teams. Front desk staff will face questions from confused patients, claims agents will process their numbers, and more.

The diversity of personal views about abortion may also affect interpersonal relations among your staff. It's important to remind staff that open forums for discussion, from meetings to internal chat boards to employee resource groups, should be grounded in mutual respect, and to find solidarity in furthering the work and mission of the health care institution itself.

Being aware of employees' emotions and wellbeing is the first step to providing them with the resources and support that they need. However, it is essential that you approach their emotional wellbeing with the utmost respect for their privacy. Anonymity is absolutely essential, so design pulse-check surveys and communication channels that are blinded and that lead with empathy—something many providers implemented in the early days of the Covid-19 crisis. Once you have a sense of your staff's emotional state, identify resources and support for all staff to access, especially targeting those who expressed negative emotions in the pulse check.

Implementation recommendations for leaders:

- Create anonymous pulse-check surveys for staff, customizing when necessary. The surveys should be optional and results should be easy to share with leaders.
- Provide surveys to all managers within the organization at the unit level, explaining to them the rationale for doing the pulse-check rapidly and regularly. Encourage empathy throughout. Specifically target staff who will be directly affected by the ruling in either their professional or personal life. Complement these surveys with optional focus groups where employees can discuss their concerns.
- Identify and promote resources that will help staff deal with changes in their working and home lives. These resources should be highly visible, centralized, and senior leaders should model and advocate their use. Resources may include access to behavioral health services or more practical guidance for employees looking to navigate the new, patchwork system of abortion access in the United States.
- Continue to conduct pulse-checks on a regular basis, encouraging their use as part of weekly meetings. Leaders should centralize results and feedback. Use the evolving data to inform employee support services and the resources they promote to staff over time.

Action step: Create a single source of truth for patients and consumers.

If providers don't anticipate what questions they'll receive and proactively prepare responses, the influx of requests will overwhelm staff, lead patients to seek services elsewhere, and create care gaps. Payers and employers will also benefit from clear information—providing answers for what services are and are not available, where services are provided, and how to access them. This situation is similar to the confusion at the start of the Covid-19 crisis, and leaders should reinstate their pandemic communication teams to provide clear information that patients, members, and staff can rely on.

Provider leaders should consolidate information on how their services will change across all relevant inpatient, ambulatory, and community sites. This information should live on a dedicated page on the institution's website and should be repeated through all communication channels, including social media. Health leaders should also consider a centralized, dedicated team of staff to keep public information updated and to field questions—whether from patients looking for clarity from their provider, employees looking for information about their health plan, clinicians trying to understand their role in the larger ecosystem.

Implementation recommendations for leaders:

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- Create a dedicated page on the institution's website that details what services each site across the system does and does not provide. Leaders can look to UPMC's website as an example of how to share information in a clear, accessible way.
- Publish a resource guide for patients with information on all available inpatient, outpatient/ambulatory, and community resources. Health systems can look to ProMedica as an example of an organization that created a comprehensive community-based resources guide for patients that lists community partners within each area by service provided.
- Assign a dedicated group of staff to field questions from patients and clinicians across the system and direct them to appropriate services/resources. This team should inform care navigators and social workers about all available services and how to connect patients to them.
- Develop a communication plan so staff, press, and community members understand how your organization supports maternal health patients.

Hard truth 3: You're facing legal uncertainty—and it's going to impact your staff in more ways than one.

Action step: Constantly ensure the workforce is aware of new (and changing) legal realities.

Dobbs v. Jackson has placed the issue of abortion access to the states, meaning that health systems must rapidly identify the new legal landscape in which they operate. These laws raise many legal questions for providers beyond simply whether they are allowed to perform abortions. For example:

- Do they have to report clinicians who perform abortions?
- Do they have to report patients who attempt to terminate a pregnancy on their own?
- Can they refer patients to an out-of-state provider?
- What level of documentation puts them at risk of litigation?
- What level of risk for the pregnant patient warrants medical intervention and how should that be documented?

In Poland, which has gradually imposed stricter restrictions upon abortion access over the last 20 years, clinicians often report 'paralysis' in making clinical decisions related to abortion, largely based on fear of legal repercussions. Without clear legal and clinical guidance on their roles, health care workers risk developing high rates of moral distress, compromising clinical safety, and adversely impacting patient outcomes.

As legal teams go into overdrive, health leaders must focus on equipping staff with the knowledge, psychological safety, and tools needed to address changing policies and their impact on care delivery. Some of these legal questions will be difficult to answer, and it is essential that health care leaders be transparent about the uncertainty they face and how they plan to respond to that uncertainty.

Implementation recommendations for leaders:

- Workforce and clinical leaders should form a working group with their legal advisors to review existing and proposed laws related to abortion access and care delivery in their state. The goal of this working group is to determine any changes in legal responsibility for providers and help answer the many questions the workforce will inevitably ask.

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- Develop a protocol for how to support staff facing legal prosecution for unintentionally abetting abortion care or for failing to provide care due to legal constraints.
- Legal advisors should hold "office hours" for staff to come and speak to them directly to clarify any questions they have about changes in legal responsibility. Legal advisors should specifically address clinicians who are likely to bear the brunt of any legal changes, such as emergency care and labor and delivery staff.
- Leaders should acknowledge that there will likely be a prolonged period of legal uncertainty related to abortion access and related legal exposure. They must be clear about what legal support they are prepared to offer to staff if employee actions result in criminal charges or lawsuits.

Action step: Adapt clinical and operational pathways in accordance with new policies.

As the legal reality in which clinicians work changes, providers may be concerned about how to provide consistent, appropriate, and high-quality care for their patients. In jurisdictions where abortion access is restricted after *Dobbs v. Jackson*, the confusion and concern felt by staff will be immediate. Absent specific plans for how to deal with situations in which the mother's life is at risk or any number of other clinical scenarios, care will be delayed and staff will face moral distress as they grapple with their own ethical dilemmas.

Clinical leaders will need to decide how to best prepare their clinicians for this shift so they can provide safe and quality care. This may mean training clinicians in the ED to recognize and manage patients presenting with symptoms of miscarriage or when it is suspected that a pregnant person has attempted to end their pregnancy. Not to mention preparing NICUs for a potential rise in volumes or changes in case mix. Even a single adverse event can put hospitals and individual providers on the front page of the local newspaper, raising the stakes for every clinical decision. Provider leaders across service lines need to come together and create functional clinical and operational pathways to ensure the well-being and safety of patients while protecting the larger organization and its clinicians and staff.

Implementation recommendations for leaders:

- Form a working group to identify any necessary changes in clinical pathways and workflows across the patient journey and in expected clinical scenarios.
- Develop clinical guidelines in partnership with legal and IT teams, ensuring that pathways reflect the changing legal landscape and that those pathways are seamlessly embedded into the workflow.
- Create clear communication channels to inform clinicians of the steps that are being taken to prepare the organization to deliver safe and effective care in the short term, taking care that some clinicians work across inpatient and outpatient settings and with a variety of care team members.
- Establish a clear chain of command to answer clinicians' questions as quickly as possible to prevent care delays.

Hard truth 4: You need to update your workforce policies—and they'll likely need to keep evolving.

Action step: Craft a benefits policy to address the geographic implications of Dobbs v. Jackson on each facility in a way that reflects your mission and keeps you competitive as an employer.

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After the initial impact of *Dobbs v. Jackson*, current staff and prospective talent will consider how the decision will influence their choice of employer. Beyond the immediate impact on mental health and wellbeing, there will be long-term impacts on lifestyle and family planning. Current staff will want to know how they will be supported through these changes and if continuing in the same role and location is worth potential new, emerging challenges. Prospective talent, including medical residents, will consider how their quality of education and how their medical practice might be different depending on state laws. Plus, the benefits an employer offers will become even more valuable to employees as their choice of workplace impacts the most personal, intimate decisions they make.

In fact, many companies—inside and outside of health care—have already started setting precedents for reimbursing travel costs and time off to access abortion care in other states. Others may consider how to expand childcare, adoption, pregnancy care, and paid parental leave benefits for their employees. Staff will be watching such changes, considering how they affect the competitiveness of your employee value proposition, and expecting clear information about how your organization will support them.

Lastly, use this moment as an opportunity to address the experiences of working parents at your organization. Studies show that over two-thirds of employees believe that working mothers are more likely to be passed over for a new job than other staff members, with some women choosing to hide pregnancy status until the last moment for fear of negative workplace repercussions. Reaffirm your organizational commitment to fair and equitable workplace treatment regardless of family status.

Implementation recommendations for leaders:

- Work with HR to clarify your position on benefits affected by or tied to the impact of abortion access. Consider the following questions as guidance:
  - Will you increase childcare benefits?
    - Will you construct childcare facilities?
    - Will there be stipends for childcare if there are no on-campus facilities?
    - Is there sufficient paid parental leave or PTO allowances for child-related emergencies?
  - Is there sufficient health plan coverage of reproductive care and family planning, including medications, surgical interventions, etc.?
  - Do you offer family planning education or couples counseling for staff?
  - Is there sufficient mental health support, including resources for abuse victims that become pregnant?
  - Will you offer travel pay and other cost-coverage to staff who opt to receive care in a state with greater abortion access?
- Continually conduct comprehensive local market scans of what benefits competitors are offering their employees. The prevalence of certain benefits, including among organizations outside the health care space, will drive employee expectations of what you can offer.
- Provide space in the workplace to show organizational support for working parents. Consider developing an employee resource group for working parents and/or for pregnant employees.

Action step: Address the implications of restricted abortion into professional development strategy.

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Organizations must rapidly assess how to use their employee learning and development functions to address the specific clinical and workforce needs stemming from *Dobbs v. Jackson*. Educational scope will likely change in states that outlaw abortion, and residency programs and other educational opportunities will shift in conjunction with emerging laws and regulations. In addition, residents and employees who require continuing education will want clarity on what they can and cannot learn, and what clinical actions they can and cannot take at your organization.

All clinicians will need to receive education and guidance about new legal and ethical responsibilities in jurisdictions where abortion access will change. As the clinical impact of *Dobbs v. Jackson* becomes clearer, staff will also need to understand how to provide different maternal health care for potentially new patient populations. Without addressing these areas, employers will lose out to talent and to employees prioritizing career development opportunities.

Implementation recommendations for leaders:

- Liaise with medical education providers and licensing bodies to understand evolving educational expectations and practices for providers. Maintain an open line of communication, as regulations may change rapidly.
- Provide regular (re-)training for staff on any changes to their legal or ethical responsibilities dependent on the impact of *Dobbs v. Jackson* on the state(s) where your organization operates
- Partner with experienced maternal health providers to train and staff for potential changes in case mix, depending on the impact of *Dobbs v. Jackson* on your state. For example, some providers may need to prepare emergency care clinicians to support patients with symptoms of miscarriage or self-administered abortion.

Hard truth 5: You're going to face growing demand for women's health care—while OB economics deteriorate.

Action step: Critically evaluate obstetrics unit finances and proactively plan for gap-filling services.

Historically, many providers have chosen to close OB units when birth rates increase at the same time that a rising unfavorable, Medicaid-heavy payer mix is met with clinician shortages. The business risks outlined in this report point to these scenarios becoming more common, particularly in areas where abortion is the most restricted.

If leaders do not judiciously assess their OB unit finances in the wake of these impacts, they risk broader facility insolvency. They also risk drops in quality, patient trust, and staff engagement that often come when demand and resources are mismatched. These are precedented risks that have driven the closure of roughly 200 labor and delivery (L&D) programs since 2004 and left over half of rural counties without an OB unit and without a practicing ob/gyn.

Implementation recommendations for leaders:

- Examine current OB unit finances and how they have shifted following *Dobbs*. Specifically, consider the following trended metrics across low-risk and high-risk births as well as for your program overall:
  - Total direct volumes
  - Payer mix
  - Per-case reimbursement
  - Fixed costs

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- Variable costs
- Tracked downstream volumes and benefits, such as NICU days, outpatient follow-up visits, mental health, etc.

- Compare the relative costs, revenues, and market opportunity of obstetrics against other services and broader organizational aims. Leaders should assess the following to understand how reallocating limited dollars to another service may better align with financial, quality, and growth goals:
  - Total revenue
  - Market share
  - Volume, revenue, and market share growth trends
  - Comparable quality metrics, such as adverse events, readmissions, etc.
  - Observed associations between volume and quality metrics
- Consider the input and buy-in of organizational stakeholders, clinicians, and patient representatives. With a workforce already facing burnout and limited resources as well as a patient population in turmoil, many parties have a stake in your decision. There are several forums for gathering this feedback:
  - Group or one-on-one clinician discussions
  - Clinician and patient surveys
  - Town or community hall open mic events
  - Cross-stakeholder working groups
- Openly communicate changes to the community, especially changes to the OB unit. Work with physicians to determine where patients will deliver, hold "town hall"-style meetings to discuss your decision-making process, and announce closures well in advance to give patients time to reconsider where to deliver.
- Should an obstetrics unit ultimately have to close, immediately begin practicing logistical coordination to the closest OB programs. To minimize unanticipated impact to surrounding OB units, prepare for site operations on moving day by holding a "mock move" to prepare staff, plan for EMS transfers, and incorporate local volunteers to help coordinate activities.

To further guide your rationalization decisions, reduce potential consequences of L&D closure, and understand the potential role of health plans in improving maternity outcomes, see our recent publications: Service rationalization toolkit, Leading service rationalization decisions, Communicating about rationalization decisions, How to mitigate the long-term effect of OB unit closures, and How 2 organizations provide accessible pregnancy care.

Action step: Support holistic women's health across all service lines.

Despite the steps leaders can take to optimize their obstetrics programs and mitigate the business risks, there will be cases where it is not financially feasible to continue operating an L&D unit. In these cases, leaders must take steps to ensure gap-filling services. If providers do not ensure access to prenatal care and other women's preventive services in the absence of an OB unit, they risk adverse patient outcomes. Studies have shown that a lack of prenatal care increases the likelihood that a patient will die from a pregnancy-related outcome by three to four times. These care gaps also decrease staff morale, reduce patient and community trust, and for systems in urban areas with comparably located OB units, a forfeit of up to 70% of the volumes that could have been captured at the initial site.

Even outside of direct unit closures, all providers can benefit from taking an expansive definition of women's health beyond pregnancy care, elevating the needs of patients

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across all service lines, and throughout all stages of the patient's life. Some may take this opportunity to invest in women's health as a dedicated service line, whose leaders have access to a unified data set that aggregates information related to women's health from all parts of the business.

Of course, not all providers should create a women's health service line. Rather, it is particularly timely for providers to assess the opportunities in their individual markets to determine how best to cater to patients who need these services. These opportunities may include shifting services to be closer to the patient by leveraging telehealth or consolidating services into women's health ambulatory centers, for example.

Implementation recommendations for leaders:

- Perform an audit and identify opportunities to embed holistic women's health services across your business. For example, providers can integrate behavioral health into ob/gyn and maternal health services. St. Joseph's Health Care in Ontario, Canada, set up a Women's Health Concerns Clinic to provide behavioral health assessments, consultations, and treatments for premenstrual syndrome, post-partum depression, and the menopause transition. Community partners and local primary care doctors routinely refer high-risk patients to the clinic early in their pregnancies. This preventive approach is so effective that the clinic reports a rate of post-partum depression less than half that seen by neighboring systems.
- Consider alternative access points using telehealth or mobile clinics. According to Advisory Board research, telehealth modalities such as virtual visits can be used to replace a portion of routine pregnancy checkups or facilitate consults with specialists. Maternal fetal medicine (MFM) specialists are scarce, and recruiting them to rural areas is difficult. Health systems can fill a service line gap by using telehealth to provide MFM services even if volumes don't support a full-time specialist. Additionally, some health systems have begun using mobile clinics to provide prenatal care.
- Train your existing workforce in women's and maternal health**.** According to CMS, there are opportunities to leverage the existing health care workforce to improve access to maternal health services. For instance, health systems can train nurses to educate women about health risks and warning signs throughout pregnancy or leverage social workers to address substance misuse and mental health concerns. To prepare for pregnant patients seeking care in the ED, leverage emergency medical services in pre-hospital management of OB care for pregnant patients in trauma situations. Next, train ED staff to handle emergent deliveries and have protocols in place for complex patients.

Action step: Address the root causes of maternal health inequities.

The increased emphasis on racial health equity in the wake of the racial justice uprisings in 2020 led many health care organizations to name maternal health equity as a key priority. The overturning of *Roe v. Wade* presents a significant challenge to those efforts. Patients of color already face disproportionate rates of maternal mortality and morbidity (the maternal mortality rate for Black patients is 3.3x the rate for white patients). These patients will also be disproportionately impacted by abortion bans, sparking many fears that maternal health inequities will only worsen.

Expect the *Dobbs* ruling to increase scrutiny around your maternal health equity strategy. View this as an opportunity to renew and expand your investments. Because while many organizations have already made significant investments in maternal health (or at least made public statements of that commitment), most strategies are too narrowly focused on improving protocols for labor and delivery, even though the majority (64%) of pregnancy-related deaths occur before labor and in the immediate postpartum period. In addition, many conventional strategies aimed at supporting maternal health miss opportunities to address the root causes of maternal health inequity: enduring

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legacies of institutional racism hardwired into policy, social institutions, and culture; as well as the diminished priority of women's holistic health care across the life span, particularly in favor of fetal outcomes.

Though the root causes are complex, there's good news: The industry has surfaced proven action steps that can reduce disparities.

Implementation guidance:

- Ensure evidence-based care standards are embedded into frontline practice. There are clinical protocols that, when used, can reduce the number of "near misses" during labor and delivery. All OB practices should immediately implement these "no regrets" standards, if they haven't already. Health plans can support provider organizations in making this transition, which requires an intentional and standardized approach to frontline training.
- Track performance and identify care gaps. Once provider organizations have no-regrets safety protocols in place, institute ongoing feedback mechanisms to monitor adherence to care standards and identify other gaps in maternal care. This includes expanding existing maternal mortality review boards to multidisciplinary perinatal review committees that can assess any "near miss" across the care journey and using race-stratified data and community input to identify care gaps (e.g., patient satisfaction, social needs).
- Tap into system- and community-based resources to design solutions in partnership with the most impacted groups, especially Black and Native American patients. Prioritize partnerships that connect frontline staff to ongoing cultural humility and clinical training, refer patients to perinatal-specific behavioral health care, address patient social needs, integrate midwifery and doula groups into care, and invest in telehealth capabilities to improve patient access.

For more on this issue, review our take on Addressing the Root Causes of Maternal Health Inequity.

Conclusion

In a highly regulated industry with an emphasis on compliance, it is only natural that the legal uncertainty and complexity unleashed by the Supreme Court ruling would be unsettling for employees and leaders alike. The business challenges we highlight in this report are not comprehensive, but they are the clearest at this early stage and the most urgently faced. They will certainly be difficult to “get right” in a way that satisfies everyone. Health care leaders must choose this moment to communicate more, listen more, measure more, and self-examine more than they would normally do. That is the path to better engagement and better results for your business, your people, and your patients.

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