POLICY BRIEF

Weitzman Institute
inspiring primary care innovation

Examining **Women's Health** in Ohio through Project ECHO®

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It is vital that all PCPs remain up to date on the complex health issues impacting women, such as, **prevention and screening**, **medical and chronic conditions**, **mental health**, **reproductive health**, and **population health disparities** to address the professional gap and improve women's health outcomes.

Weitzman ECHO Women's Health

18, twice-monthly sessions were held between March and December 2022.

A total of **69 participants attended at least one session**, including 20 medical providers, 5 behavioral health providers, and 44 care team members.

I. Background

In the United States (U.S.), maternal morbidity and mortality are major health concerns.[i] **In addition, there are extreme racial and ethnic disparities in rates of maternal morbidity found within various states across the country, including in the state of Ohio. Between 2008 and 2017, Black women living in the state of Ohio were more than twice as likely to die from a pregnancy-related cause compared to white women.**[ii] A recent Ohio Department of Health report demonstrated that Black, non-Hispanic women (112.2) experienced a 1.85 times higher rate of maternal hospitalizations per 10,000 deliveries than the state's average rate for white women (60.5). In addition, Black, non-Hispanic women and Asian, non-Hispanic women (84.6) surpassed the state's overall rate of 71.9.[iii] While some women seek care with women's health providers such as obstetrician-gynecologists (OB/GYNs), many others, especially those in resource-limited areas, receive care only from their primary care provider (PCP), including prior to and shortly after giving birth.[iv v] Therefore, it is vital that all PCPs remain up to date on the complex health issues impacting women, such as, prevention and screening, medical and chronic conditions, mental health, reproductive health, and population health disparities to address this gap and improve women's health outcomes. The purpose of this policy brief is to discuss key findings on the barriers and gaps in care related to women's health identified by participants who participated in the Weitzman ECHO Women's Health continuing education series and provide policy recommendations.

II. Methodology

Weitzman ECHO Women's Health was funded by **Buckeye Health Plan**, a subsidiary of the Centene Corporation, a Medicaid/Medicare provider in Ohio, and developed in partnership with **Ohio University Heritage College of Medicine**. This program consisted of 18, twice-monthly sessions held between March and December 2022. Each session met for one hour and included a 20- to 25-minute didactic presentation by one of the expert faculty members. The remaining 35–40 minutes allowed participants to share and discuss real life patient cases through a case presentation, with clinical recommendations from the expert faculty and advice from their peer participants. This program aimed to provide targeted support and education related to women's health related issues to Ohio primary care medical providers (physicians, nurse practitioners, and physician assistants), behavioral health providers, and other care team members working with adolescent and adult patients in community healthcare settings in Ohio, with a specific focus on southeast Ohio. A total of 69 participants attended at least one session, including 20 medical providers, 5 behavioral health providers, and 44 care team members. Of these participants, 14 participants attended between 5-8 sessions and 26 participants attended over 9 (half) of the sessions.

This policy brief contextualizes data collected from Weitzman ECHO Women's Health participants, alongside an analysis of current literature and resources relating to women's healthcare in the state of Ohio and nationally. Over the course of Weitzman ECHO Women's Health, two surveys and five interviews with key informants were administered. The program's pre-series and post-series surveys were used to collect information about the participants, evaluate the program, and identify the key barriers and gaps they face when addressing women's health needs in their practice. For the pre-series survey, 76% of participants (n=57) completed the survey, while 23% of participants (n=18) completed the post-survey.

This brief focuses primarily on the barriers and gaps in care relating to women's health identified by participants. Using a grounded theory approach[vi], which is an inductive analytical form of qualitative analysis, barriers and gaps reported in the survey were categorized into codes and then themes. These themes were then used to inform the semi-structured interview guides. Key themes identified by survey responses for barriers to women's health access were: social determinants of health (n=34) such as transportation, cost, and lack of social support; structural limitations (n=24) such as a lack of resources or institutional knowledge; and patient challenges (n=7) such as lack of a patient-centered approach to best practice and challenges with follow-up. Additionally, the survey revealed crucial gaps regarding women's health in: access to care (n=20) such as mental health access and transitioning of care; structural gaps (n=12) such as knowledge gaps and resource challenges; social determinants of health gaps (n=10) such as transportation and financial gaps; and gaps in delivering patient-centered care (n=3) such as gender-sensitive care.

The semi-structured interviews were used to contextualize the identified barriers and gaps within the experiences of key ECHO participants. Participants interviewed represented a multitude of professional backgrounds, including a public health employee, a nurse practitioner in private practice, an OB/GYN provider in private practice, an internal medicine specialist provider and chief medical officer of a primary care federally qualified health center (FQHC), and a family health provider who served as faculty on the ECHO. The interviews addressed what barriers and gaps from the themes identified in the survey responses were most prevalent in Ohio communities and explored some potential solutions that may be employed to mitigate the effect these barriers have on women's healthcare services. These barriers and challenges are explored in the sections below. Utilizing these data sets, contextualized with emerging literature and resources from Ohio, this brief discusses barriers to women's healthcare in the state of Ohio from the perspective of healthcare practitioners.

Barriers to women's health access include:

- **Social determinants of health**
  Transportation, cost, and lack of social support
- **Structural limitations**
  Lack of resources and institutional knowledge
- **Patient challenges**
  Lack of patient-centered approach to best practice and follow-up

Gaps include:

- **Mental health care**
- **Gender-sensitive care**
- **Transitioning of care**

III. Key Findings

KEY FINDING #1: Staff Lack Cultural Competency to Provide Culturally-Appropriate Care

Respondents spoke about racial bias towards Black patients, the lack of racial concordance among the healthcare workforce in Ohio, and the lack of focus on health equity and cultural competency. One respondent spoke on the lack of recognizing the impact of racism on patients' health by stating, *"One of the things that I think is missing [in many practices] is the impact of bias or racism, all of that is missing from the patients' experience overall, providers' thoughts and the impact of that on the social determinants of health."* Another respondent discussed the lack of racial concordance among healthcare providers and patients' health, *"…We don't have a lot of African American doctors, and there are a lot of things that are not only cultural but you know there are things that happen to African Americans that don't happen to any other race. There are specific things that if a doctor doesn't know about, and they're trying to treat you, they're not treating you appropriately and it could be intentional or not intentional."* Demographic data supports these respondents' statements about the lack of racial concordance in the healthcare workforce in Ohio (see Table 1).

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Table 1. Race/Ethnicity of Ohio's Population and Healthcare Workforce

Race/ Ethnicity	Ohio General Population (2021)	Physicians (2015–2019)	Physician Assistants (2015–2019)	Psychologists (2015–2019)	Registered Nurses (2015–2019)	Medical Assistants (2015–2019)
White*	80%	69%	90%	87%	87%	80%
Black*	13%	5.4%	N/A	7%	8.2%	13%
Hispanic	4%	3.4%	N/A	2%	2%	4%

Source: United States Census Bureau. QuickFacts, Ohio, 2022. https://www.census.gov/quickfacts/OH. Health Resources and Services Administration. Area Health Resources Files, 2022. https://data.hrsa.gov/topics/health-workforce/ahrf

*Non-Hispanic

Racial/ethnic minorities in the U.S., particularly Black Americans, experience health disparities, including being more likely to be uninsured, have chronic health conditions, and less likely to receive mental health services.[vii] Black Americans are also more likely to report experiencing discrimination in the healthcare system and having poorer patient-physician communication.[viii ix] Black women, especially, experience discrimination in the healthcare system, particularly when it comes to their reproductive health. **71% of Black women aged 18–49 stated they experienced a range of negative experiences from healthcare providers**, and Black women often experience a lack of shared decision-making, stereotyping, being dismissed by healthcare providers, and medical distrust.[x xi] Black women's negative experiences within the healthcare system are evident in that Black women are three times more likely to die from pregnancy complications than White women.[xii] A statewide survey in Ohio reflects national data on the experiences of Black Americans in the healthcare system. **Sixty percent and 41% of Black women and men, respectively, reported that their symptoms were dismissed compared to 52% of White women and 20% of White men.**[xiii] One reason that Black Americans experience discrimination in the healthcare system and health disparities is the lack of racial concordance in the healthcare workforce. A lack of diversity within healthcare professions can impact access to healthcare, health outcomes, and health equity for racial/ethnic minorities. Racial concordance between healthcare providers and patients is needed in Ohio as it has been associated with improved communication, health outcomes, and patient satisfaction.[xiv xv]

KEY FINDING #2: Access to and Utilization of Mental Health Services are Inadequate

According to the Health Policy Institute of Ohio, there is a growing need for mental health services. **The percent of Ohio adults reporting frequent poor mental health days increased from 12.7% to 15.3% from 2011 to 2020.**[xvi] ECHO participants and interviewees recognized this growing need and cited challenges in access to mental health services for their patients, including insurance coverage and societal stigma of receiving care. They noted that lower-income patients and Medicaid beneficiaries encounter additional barriers due to mental health providers not accepting Medicaid or individuals with no insurance. In 2018–2019, 29.1% of adults with any mental illness in Ohio reported having Medicaid coverage. A participant spoke on this challenge by saying *"I think the mental health access…that's a problem everywhere. Like, we have a hard time getting people into counselors, certainly to psychiatrists just because of the lack of numbers of providers that take their insurance, especially with (patients with Medicaid)."*

The challenges around mental health service utilization in Ohio highlighted by the participants are reflected in recent data. **Although the percentage of people who received mental health treatment from 2018–19 was higher than the national average (19.3% vs. 15.6%), 25% of Ohio adults reported that they needed mental health treatment and did not receive it.**[xvii] Cost and availability of providers are barriers that prevent Ohioans from receiving care. Among the adults in Ohio who reported an unmet need for mental health treatment in the past year, 38% did not receive care because of cost.[xviii] Additionally, nearly 2.4 million people in Ohio live in communities without enough behavioral health professionals to meet the need, and although the workforce increased 174% from 2013–2019, demand for behavioral healthcare services in Ohio increased 353% in the same timeframe.[xix]

KEY FINDING #3: Organizational and Individual Challenges Exist to Advancing JEDI-Centered Cultural Change

ECHO participants discussed that there was a lack of motivation, both by individual staff members and by the organization, to develop and implement efforts that support cultural change within the organization. **This change centered on Justice, Equity, Diversity, and Inclusion, is known as JEDI.** One participant expressed that *"… we will be challenged by people who like the status quo of what it is. I think we'll be challenged by people who don't embrace or celebrate concepts of diversity, and so may see this as not relevant. I think*

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it's a matter of how it's messaged and helping people to understand the importance of the 'why' and tying it back to what we hope to see and improve outcomes in our state." This quote speaks to the impact that not addressing cultural and inclusion disparities can have in not only patient outcomes and satisfaction, but in staff satisfaction as well.

With hospital and healthcare leadership having a higher proportion of White people and men, compared to the overall workforce, this finding highlights that staff feel like more needs to be done to meet the cultural and equity needs of staff and patients. Barriers including cost, lack of buy in, and lack of vision are all hindrances to advancing cultural change within a healthcare organization.[xx] Both the leaders and staff play key roles in implementing change within organizations. Studies show that the lack of goal setting, clear communication about the vision and changes being implemented, staff buy-in, and incentives to create an inclusive workplace and improved patient experience prevents meaningful change from being implemented.[xxi] However, organizational changes led by staff that were communicated clearly, and where the value of the change to staff and patients was clear, were more likely to succeed.[xxii xxiii]

Addressing the barriers listed above would have positive impacts on both the organizational and individual levels. Studies show that staff who feel included by their organization are more likely to feel excited and committed to them.[xxiv] Further, there are recruitment and retention implications. One survey showed that respondents from all demographics say they have considered organizations' inclusiveness when making career decisions and would like their organizations to do more to foster inclusion and diversity.

KEY FINDING #4: Transgender Patients Face Additional Barriers in Receiving High-Quality and Appropriate Care

Women's Health ECHO participants felt like transgender patients encountered additional barriers to receiving high quality and appropriate care. These barriers included the lack of knowledge of transgender care and difficulty in referring patients out. One participant said, *"I just feel like many people don't talk about it, most people don't have experience with treating trans people, or are fearful of it. They try to avoid it, and I think, like it's really a disservice for these patients, because they—you know—have already been traumatized often from the medical system."* This quote highlights the challenges providers who serve transgender patients face in developing care plans with their patients that involve external providers and specialists. Participants noted that when referring transgender patients for surgery or hormone therapy, there is a lack of providers who are able or willing to accept the patient. In fact, one participant shared an experience they had when referring a transgender patient out for gynecological surgeries, the receiving office said *"doctors need to think about this and meet together and vote to see if we're gonna do surgeries for these people."*

There are also state level policies that create confusion and uncertainty on the care that transgender patients can receive and that are covered by insurance. Transgender people are more likely to participate in government programs, such as Medicaid, whose coverage and policies differ by state.[xxv] Even though the Affordable Care Act created protections in 2016 for transgender individuals for plans sold through the Marketplace and added gender-affirming surgeries to a list of medically necessary procedures Medicaid must cover, Ohio maintains a policy that explicitly excludes coverage for gender-affirming care under their state Medicaid program.[xxvi] In July 2021, Governor Mike DeWine approved language in the 2022–2023 budget permitting doctors, nurses, and other health practitioners to "decline to perform, participate in, or pay for any health care service, which violates the practitioner's, institutions, or payer's conscience."

There is data showing that the barriers highlighted above impact transgender people in Ohio and the United States at large. Transgender patients face higher rates of discrimination in the healthcare system and are more likely to experience poor health outcomes.[xxvii] The Center for American Progress conducted a survey in 2020 of LGBTQI+ adults, which found that 28% of transgender respondents reported postponing or avoiding necessary medical care in the year prior for fear of experiencing discrimination. In that same survey, 40% of transgender respondents reported postponing or avoiding getting preventive screenings due to discrimination, including 54% of transgender people of color.

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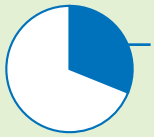
The Center for American Progress Survey of LGBTQI+ Adults:



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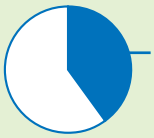
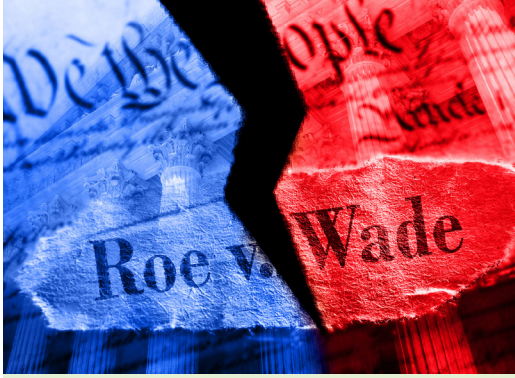


40% of transgender respondents reported postponing or avoiding getting preventive screenings in 2019 due to discrimination, including **54% of transgender people of color**

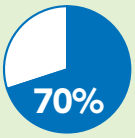
KEY FINDING #5: Uncertainty of Current and Future Reproductive Health Policies Results in Fear-Based Decision-Making

On June 24, 2022, the Supreme Court overturned Roe v. Wade, which established that abortion is a constitutional right.[xxix] Following the Supreme Court's decision, 13 states have banned abortion, either with or without exceptions, five states have placed gestational limits, and six states, Ohio included, have had their bans on abortion blocked by judges.[xxx] Because a county judge in Ohio temporarily blocked the ban, abortions can continue up to 20 weeks of pregnancy.[xxxi] With the recent passing of abortion bans across the U.S., there are fears among patients about the certainty of current and future access to reproductive health services. During key informant interviews, one respondent noted an increase in tubal ligations among patients due to fear of uncertainty in being able to access reproductive health services should they become pregnant. This sentiment has also been echoed by other healthcare providers across the state and the U.S., stating that individuals are seeking voluntary sterilizations to prevent unintended pregnancies.[xxxii xxxiii] While evidence-based research is needed to fully comprehend the impact of restrictive reproductive health laws, current anecdotal evidence suggests that individuals are making reproductive healthcare decisions based on fear.

Key informant interviews found that there is a lack of knowledge regarding policies and best practices in reproductive health due to Roe v. Wade being overturned. One respondent stated, *"I think the difficulty now is knowing what we can and can't do from a legal standpoint.... Right now in Ohio there's a stay on legislation, so our options are still there, but I still think there's a fear there."* Healthcare providers across the U.S. have expressed similar statements. A survey of 243 U.S. physicians found that 70% are unsure about what is considered a life-threatening emergency that would allow for an abortion in states where it is banned, and 89% stated they feel they will have to make medical decisions based on legally protecting themselves when deciding to perform an abortion.[xxxiv] Healthcare providers are also having to rely on lawyers for counseling to determine if they are allowed to perform an abortion in a life-threatening situation, but they don't always have time to call a lawyer in emergency situations.[xxxv xxxvi] The confusion healthcare providers are experiencing regarding abortion speaks to the lack of clarity and vagueness in language in abortion legislation.[xxxvii]



Of 243 U.S. Physicians Surveyed:



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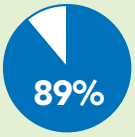

89% make medical decisions based on legally protecting themselves when deciding to perform an abortion

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IV. Recommendations

RECOMMENDATION #1: Increase Cultural Humility Among the Healthcare Workforce

There is a need for cultural humility trainings for healthcare professional students and healthcare workers in Ohio to address health disparities among Black patients. Drs. Melanie Tervalon and Jann Murray-Garcia developed cultural humility to address health disparities and inequities within the healthcare system, and it has three principles: lifelong learning and critical self-reflection, recognizing and changing power imbalances, and institutional accountability.[xxxviii] Cultural humility can reduce implicit bias and improve healthcare as a whole.[xxxix] The Liaison Committee on Medical Education has included a cultural curriculum in undergraduate medical education; however, cultural humility has not been widely implemented across medical education.[xl] Health professions schools in Ohio can implement cultural humility trainings and modules similar to the University of Nevada, Reno, School of Medicine's Acceptance and Commitment Training (ACT). ACT was used to teach cultural humility to medical students enrolled in a medical Spanish course.[xli] Thirty-one students completed online cultural humility training modules, and after the training, there was an increase in cultural humility among students, a higher favorability rating toward different ethnicities, and improvements in attitudes, knowledge, and beliefs.[xlii]

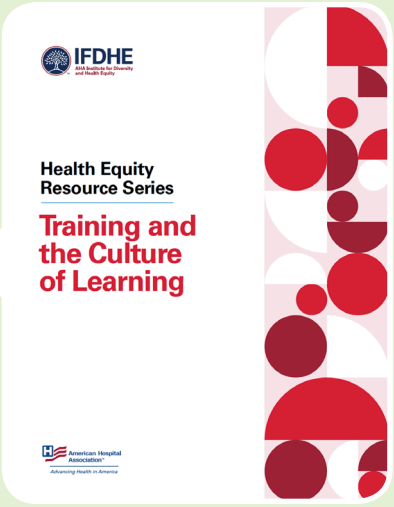
Healthcare organizations in Ohio would benefit from creating a culturally-aware environment among their healthcare staff. There are social, health, and business benefits of being a culturally-aware healthcare organization, such as increasing trust and mutual

Cultural humility addresses health disparities and inequities within the healthcare system.

The three principles of cultural humility are:

- **Lifelong learning and critical self-reflection**
- **Recognizing and changing power imbalances**
- **Institutional accountability**

respect between patients and the organization, including community members, reducing health disparities, and improving efficiency of care services.[xliii] The American Hospital Association (AHA) has developed a toolkit for healthcare organizations seeking to implement cultural humility into their care and practices. Healthcare workforce cultural humility training should include: conducting cultural assessments to understand staff's knowledge of cultural humility, identifying training topics such as anti-racism or implicit bias, offering multiple training methods such as case studies and online modules, and measuring and tracking to evaluate staff on their knowledge, understanding, and skills.[xliv] RWJBarnabas Health has found some success by focusing on health equity and diversity and inclusion. In 2016, they partnered with AHA and other healthcare associations to increase cultural awareness and diversity.[xlv] Between 2017 and 2020 they had a 6% increase in racial/ethnic minority hiring, implemented an implicit bias and cultural humility e-learning training module for healthcare providers, and had open discussions regarding race, racism, and implicit bias.[xlvi] Directors and board of trustees also completed implicit bias and cultural sensitivity training.[xlvii] These examples can help healthcare organizations in Ohio reduce health disparities and reduce implicit bias that may be present in their practice. These organizations should ensure that all staff, from leadership to entry-level staff, commit to ongoing cultural humility learning.



Source: American Hospital Association

RECOMMENDATION #2: Support Workforce Diversity Development and Pipeline Efforts

Given the lack of racial concordance in Ohio between providers and patients, Policymakers should invest in and expand efforts that aim to increase the number of people of color in the healthcare workforce. Investing in the healthcare workforce pipeline will address the workforce shortages that currently exist and reduce the racial/ethnic disparities of providers and other clinical staff to increase racial concordance in the healthcare system in Ohio, resulting in improved health outcomes and increased patient satisfaction.

There are several strategies that can support the entry and retention of underrepresented groups into medical education and the workforce. First, the medical school enrollment process must be improved by implementing a holistic review process, which is when schools take into consideration more than just the applicants' academic metrics, and values the person's experiences, attributes, and how they would contribute to learning, practice, and teaching.[xlviii] These initiatives have shown to increase diversity in schools.[xlix] Second, financial barriers to attending medical school should be addressed by increasing investment in federal funding programs for medical school education. Programs like the Health Careers Opportunity Program, Centers of Excellence, and Scholarship for Disadvantaged Students provide scholarships, grants, and loans to those from underserved and disadvantaged communities and can relieve some of the financial barriers that may prevent these students from attending medical school. Lastly, medical schools should invest in mentorship and social support programs for students of color to help them navigate professional opportunities, promote inclusion, and invest in their retention.

Efforts must also be made to retain people of color once they enter the healthcare workforce. Other members of the healthcare team, including Medical Assistants and Community Health Workers (CHWs) are more racially diverse than their provider and registered nurse colleagues and it is important that these staff members be considered. By developing career ladders and supporting career advancement, it allows these professionals to move into other roles, which will enable the continued diversification of the workforce, as well as help meet the growing demand for healthcare professionals.

Strategies that can support entry and retention of underrepresented groups into medical education and workforce:

- **Implementing a holistic review process to medical school enrollment**
- **Increasing investment in federal funding programs for medical school education**
- **Investing in mentorship and social support programs for students of color**
- **Developing career ladders**
- **Supporting career advancement**

RECOMMENDATION #3: Support and Expand Alternatives Models of Mental Healthcare

It is important that the mental health needs of Ohioans are addressed. Unmet mental health needs can worsen if left untreated, and can affect physical health, lead to substance misuse, and decrease quality of life.[l] Ohio policymakers and healthcare

administrators should invest in and expand alternative models of mental healthcare, including community care models. Community care models utilize people from the community to support others in their broader community, and who have an understanding of their needs, culture, and environment. CHWs and Peer Support Workers are two professions that can help those with mental health needs get connected and receive support. Along with addressing the workforce shortage these alternative support services may remove additional barriers to care such as cost and stigma by educating and conducting outreach on mental health within the community.

CHWs have been a growing profession and increasingly recognized members of the healthcare team and have been shown to improve health outcomes.[li] They are well-situated to help meet the needs of underserved populations because they typically come from the communities they serve and can provide linguistically and culturally appropriate care. They can be formally or informally trained in mental health, and have the necessary skills to support those in need.[lii] CHWs can also connect community members to mental health resources and help them navigate the healthcare and social service systems to ensure that they get the support they need. There are efforts to grow the CHW workforce in Ohio, including the Ohio Department of Health's Office of Health Opportunity Community Health Workers Workforce Development Initiative. There are also many CHW training and certification programs offered through University, community and technical schools, and nonprofit organizations.

Peer Support Specialists are increasingly utilized to support those with mental health and substance use disorders and have become an important part of Ohio's behavioral health workforce.[liii] Like CHWs, Peer Support Specialists typically come from the communities they serve. In addition, they have lived experience with navigating the challenges of mental health and/or substance use recovery, so that they can use this experience to support others. They have been shown to increase engagement in the recovery process, reduce hospitalizations, and improve overall well-being of individuals.[liv] The state of Ohio has several initiatives focused on increasing support and services for substance use disorders and mental health. The Ohio Department of Mental Health and Addiction Services offers a Peer Supporter certification program, and Governor Mike DeWine also commissioned RecoveryOhio, which coordinates recovery, prevention, and workforce development efforts across the state. Policymakers should continue investing and expanding these efforts and build on successes.

Community care models utilize people from the community to support others in their broader community, and who have an understanding of their needs, culture, and environment:

- **CHWs**
  Typically come from the communities they serve and can provide linguistically and culturally appropriate care.
- **Peer Support Specialists**
  Have lived experience with navigating the challenges of mental health and/or substance use recovery.

Recommendation #4: Adopt a Patient-Centered Approach to Transgender Healthcare

Given the challenges transgender patients face when navigating the healthcare system, healthcare organizations and policymakers should adopt patient-centered and evidence-based approaches for transgender healthcare. When possible, healthcare administrators should include transgender people, those with lived experience, and subject matter experts in decisions regarding policies and procedures for transgender healthcare. These efforts may help transgender patients have access to safe and culturally appropriate care environments, receive higher-quality of care, and experience fewer barriers to care. Adopting these best practices will result in better outcomes, culturally-appropriate care, and increased patient satisfaction.

As cited in Key Finding #4, one major barrier to providing high-quality care to transgender patients is the lack of knowledge both clinical and administrative staff have in caring for, and the lack of organizational capacity to adequately serve this population. To address this gap, healthcare staff should receive training and education on evidence-based best practices and guidelines, including cultural humility trainings as outlined in Recommendation #1. These best practices include using the preferred names and pronouns of patients, learning basic terminology used by the transgender community, and approaching individuals with cultural humility when determining which specific terms to use.[lv] Further, healthcare organizations should implement policies and procedures that align with best practices. These include asking about gender identity and preferred name and pronouns on registration forms and using this gender identity data to inform future planning and policy discussions on the needs of their transgender patients.

Recommendation #5: Provide Further Clarity on Current Reproductive Health Laws

Nine months after the Supreme Court overturned Roe v. Wade, states that have banned abortion are now having to make amendments to abortion legislation to clarify confusing language that has prevented healthcare providers from performing abortions in medically necessary situations. Three states, West Virginia, Tennessee, and Texas, are considering new legislation to clarify language in their abortion bills. In WV, policymakers are considering providing women with information and support to have informed consent for abortions, such as establishing a 24-hour hotline provided by the public health department and perinatal hospice service.[lvi] The state also consulted with OB/GYNs to ensure that language in the bill allows for them to perform abortions as a standard of care when medically necessary.[lvii] Tennessee's House Bill 883 seeks to remove language that prevents physicians from performing an abortion to save a mother's life and to remove the threat of prosecution.[lviii] Texas has two bills currently in its legislature to clarify language of when exceptions for abortion are allowed, such as a nonviable pregnancy and when the health of the mother is threatened.[lix] Should Ohio be able to implement a six-week abortion ban, Ohio policymakers need to consult with healthcare experts, like OB/GYNs, to ensure that language in the bill is clear and medically accurate, and to provide guidance to healthcare providers and the public, such as hotlines to provide information regarding abortion policy.

Ohio policymakers need to consult with healthcare experts to ensure that language in a proposed six-week abortion ban bill is:

- **Clear and medically accurate**
- **Provides guidance to healthcare providers and the public through information resources such as hotlines**

V. Acknowledgments

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