The CenteringPregnancy Model

The Power of Group Health Care

SHARON SCHINDLER RISING
CHARLOTTE HOUDE QUIMBY

SPRINGER PUBLISHING COMPANY
“Centering is more than just giving care to people in a group setting. It’s a powerful tool for engaging people in their care and living healthier lives. The evidence from many clinical trials confirms that it improves health outcomes, lowers costs, and leads to greater patient and provider satisfaction. This important book is crucial to spreading Centering as a fundamental approach for transforming health care delivery.”

Diana J. Mason, RN, PhD, FAAN
Co-Director, Center for Health, Media & Policy
New York, New York

“CenteringPregnancy provides the opportunity for the clinician to be in true partnership with the pregnant woman through prenatal care in a group setting. This book provides the evidence base for nurses, midwives, and physicians to effectively change prenatal care in the United States. It is an important resource for both practice and academic settings.”

Holly Powell Kennedy, PhD, CNM, FACNM, FAAN
Helen Varney Professor of Midwifery
Yale University School of Nursing
New Haven, Connecticut

“A book describing Centering group health care will be useful as a resource to provide background for learners in a variety of fields, including nursing, medical school, and postgraduate residency training. Understanding basic components behind this evidence-based concept of group care will be an important adjunct for future providers of health care in a wide variety of fields and settings.”

Douglas W. Laube, MD
Past President of ACOG and Former Chair of Council on Residency Education in Obstetrics and Gynecology

“This book provides an excellent review of the science, theory, practice, and evidence of Centering Healthcare all in one place. We need more of this kind of transformative innovation in health care delivery to improve the health of our nation.”

Michael C. Lu, MD, MS, MPH
Associate Administrator for Maternal and Child Health
Health Resources and Services Administration
U.S. Department of Health and Human Services
“CenteringPregnancy has demonstrated the far-reaching positive consequences of bringing pregnant women together in interactive groups for their pregnancy care and ongoing support following birth. A sense of empowerment and the building of community through friendship networks can have a profound effect on reducing the potential stress and social isolation of new motherhood. In identifying the principles, practicalities, and evidence associated with CenteringPregnancy, this timely book opens doors of possibility across the world for clinicians who engage with pregnant women. It is a compelling resource for all those concerned with the development of cost-effective, woman-centered maternity services.”

Nicky Leap, MSc
Adjunct Professor of Midwifery, University of Technology, Sydney, Australia

“March of Dimes has funded CenteringPregnancy programs in dozens of states for over a decade. It is a proven model that has fostered better outcomes for moms and babies, including demonstrating a significantly lower premature birth rate. We wholeheartedly support implementation of CenteringPregnancy and other models of group prenatal care.”

Paul Jarris, MD, MBA
Senior Vice President, Maternal-Child Health and Deputy Medical Officer
March of Dimes Foundation

“The Centering Healthcare Institute is proud to have this comprehensive reference on the Centering model available for individuals and sites to explore, implement, and sustain Centering group care. We remain committed to this evidence-based model and its power to change lives and improve outcomes for both patients and clinicians.”

Angie Truesdale
Chief Executive Officer, Centering Healthcare Institute

“The Centering Healthcare model, already a dynamic influence on efforts to improve quality and outcomes, including satisfaction, will be strengthened and energized by this important new book. Two experienced midwifery clinicians and academic leaders have prepared a volume that not only serves the reproductive health care provider community but society in general. The model is receiving broadening consideration and implementation and deserves the reference material, knowledge, and guidance this book provides.”

George A. Little, MD, FAAP, FACOG
Active Emeritus Professor of Pediatrics and OB/GYN
Geisel School of Medicine at Dartmouth
Hanover, New Hampshire
The CenteringPregnancy® Model
Sharon Schindler Rising, MSN, CNM, FACNM, is a certified nurse-midwife who graduated from the Yale School of Nursing, taught on the faculty there, and then established the graduate nurse-midwifery program and the Childbearing Childrearing Center at the University of Minnesota. From 1993 to 1994, she developed and piloted the CenteringPregnancy® model of group health care in Waterbury, Connecticut and began doing instructional workshops nationally and internationally. She is the founder and president emeritus of the Centering Healthcare Institute, Inc. (CHI), a nonprofit organization dedicated to improving health by transforming care through Centering groups. She has been on the clinical nursing faculty at the Yale School of Nursing and is an adjunct professor at the University of Technology, Sydney, Australia. In 2006, she was named a distinguished alumna by Yale University School of Nursing, and in 2007 she was presented with the National/International Award for Outstanding Contribution to Maternal & Child Health by the National Perinatal Association. She was awarded the Purpose Prize by Civic Ventures in December 2008, and in 2010 she won the Trout Premier Cares Award, was named an Edge Runner by the American Academy of Nursing, and received the Hattie Hemschemeyer Award from the American College of Nurse-Midwives.

Charlotte Houde Quimby, MSN, CNM, FACNM, graduated from the Yale School of Nursing, taught on the faculty, and served as chair of the department of Maternal Newborn Nursing and chief nurse-midwife at Yale New Haven Hospital. In 1997, she received the Distinguished Alumna Award for Yale University School of Nursing. She developed the nurse-midwifery service at Dartmouth Hitchcock Medical Center and was a faculty member at Dartmouth Medical School, where she continues as an adjunct faculty of Community and Family Medicine. She has worked in nursing and midwifery programs internationally for the American College of Nurse-Midwives Global Division, providing training needs assessments, training, and project evaluation in Africa and Asia. She was a Visiting Senior Associate in 1993/1994 at Emory University's Lillian Carter Center for International Nursing. She served in the New Hampshire Legislature and received the New Hampshire Nurses Association Legislator's Award for Outstanding Contribution to Nursing Legislation. She was a consultant/faculty member for the Centering Healthcare Institute, Inc. (CHI) from 2004 to 2014.
The CenteringPregnancy® Model
The Power of Group Health Care

Sharon Schindler Rising, MSN, CNM, FACNM
Charlotte Houde Quimby, MSN, CNM, FACNM
This book is dedicated to the many clinicians, mothers, and families who have given and received care through the Centering Healthcare model . . .

. . . and to the clinicians, mothers, and families who informed our work over the years and made it possible for this model to give life.

It also is dedicated to our families: To Ron Rising, who has been at my side these many years and especially for his help through the conception, birth, and spread of the Centering care model and to the production of this book . . . his contribution and support continue to be enormous. To our children, Josh and Kristin, both physicians who practice in a “centering” way and who have provided a deep belief in the importance of this work. And to their spouses, Isabelle and Louis, who joined later in the process but shared their helpful insights and hope for health care reform.

To Tony Quimby for his abiding love and his belief in the importance of our work, and to my children, Bob, John, David, Judy, Beth, and Matthew Houde, their encouraging spouses, and all of our incredibly lovely grandchildren, who have cheered, inquired, supported, and helped in so many ways big and small . . . and to my dearest friends, who have been on the journey with me every step of the way.

We are hopeful that Centering Healthcare and other efforts to make relationship-centered care the standard will provide a better system of care for all of us and especially for our grandchildren.
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Contributors

Sally H. Adams, PhD, RN Specialist, Division of Adolescent and Young Adult Medicine, Department of Pediatrics, University of California, San Francisco

Nancy Bardacke, CNM, MA Director, Mindfulness-Based Childbirth and Parenting (MBCP) Program, University of California, San Francisco (UCSF) Osher Center for Integrative Medicine; Assistant Clinical Professor, UCSF School of Nursing; Founder, Mindful Birthing and Parenting Foundation (MBPF)

Lisa Chung, DDS, MPH Associate Clinical Professor, Division of Oral Epidemiology & Dental Public Health, University of California, San Francisco, School of Dentistry

Larissa G. Duncan, PhD Elizabeth C. Davies Chair in Child & Family Well-Being; Associate Professor, Human Development & Family Studies; Associate Professor, Family Medicine & Community Health; Healthy Minds, Children, and Families Specialist, University of Wisconsin-Extension; Associate Director, Center for Child and Family Well-Being, School of Human Ecology, University of Wisconsin-Madison

Sheela Maru, MD, MPH Instructor in Obstetrics and Gynecology, Boston University School of Medicine; Women's Health Advisor, Possible and Health Care Systems Design Group; Research Fellow, Division of Women's Health, Brigham and Women's Hospital, Boston, Massachusetts

Kathleen F. Norr, PhD Women, Children & Family Health Sciences, University of Illinois at Chicago, College of Nursing
Contributors

Crystal L. Patil, PhD  Associate Professor, University of Illinois at Chicago, College of Nursing

Marlies Rijnders, PhD, RM  TNO Child Health, Leiden, The Netherlands

Sandra A. Smith, PhD, MPH  Director of Research, Center for Health Literacy Promotion, Seattle, Washington

Lisa Summers, FACNM, DrPH  Former Director of Policy and Advocacy, Centering Healthcare Institute, Silver Spring, Maryland
Foreword

Despite spending more on perinatal health care than any other nation, the United States consistently ranks near the bottom among developed nations on most standard measures of perinatal outcomes. Furthermore, significant racial-ethnic and socioeconomic disparities persist. Doing more of the same will do little to move the needle. This book, *The CenteringPregnancy® Model: The Power of Group Health Care*, adds to the growing body of evidence compelling a reexamination of how perinatal health care is delivered in the United States.

For more than three decades, prenatal care has been a cornerstone of our national strategy to reduce infant mortality and improve birth outcomes. Federal and state efforts in the late 1980s and early 1990s to expand Medicaid coverage for pregnant women led to significant increases in prenatal care utilization, but not to significant improvements in birth outcomes. Two review papers published in 1995 began to question the effectiveness of prenatal care, citing problems with inconsistent results, insufficient adjustment for prematurity bias, and inadequate controls for the effects of critical confounding variables, as well as potential selection bias in earlier studies. In 2003, my colleagues and I published another review paper evaluating the evidence of effectiveness for prenatal care and concluded that “neither preterm birth nor IUGR [intrauterine growth restriction] can be effectively prevented by prenatal care in its present form. Preventing low birth weight will require reconceptualization of prenatal care as part of a longitudinally and contextually integrated strategy to promote optimal development of women’s reproductive health not only during pregnancy, but over the life course” (Lu & Halfon, 2003). Our argument was drawn from the life course perspective, which conceptualizes birth outcomes as the product not only of the 9 months of pregnancy, but of the entire life course of the mother from her conception (or before) and onward,
leading up to the pregnancy. Disparities in birth outcomes, therefore, are the consequences not only of differential exposures during pregnancy, but also of differential health trajectories across the life span. The life course perspective suggests a need for a paradigm shift in our national strategy to address infant mortality. It calls for an expanded approach to improve birth outcomes in America, one that emphasizes not only risk reduction during pregnancy, but also focuses on health promotion and optimization before and between pregnancies, and indeed across the life course. The approach needs to be both clinical and population-based, addressing both individual factors and social determinants of health.

Group health care exemplifies such an expanded approach. By receiving prenatal care in a group setting, women have more time with their providers to discuss not only clinical issues, but important concerns in their lives including social determinants. Instead of repeating the same information over and over to women, one at a time, providers in a group setting can cover many more topics that often are inadequately addressed in traditional, individualized prenatal care settings.

Some of these topics include nutrition, stress, and environmental exposures, the impact of which not only on pregnancy outcomes but also on developmental origins of health and disease is increasingly recognized. Providing care in this way allows women to get to know one another and their providers on a much deeper and meaningful level, which can lead to greater engagement, learning, and self-confidence. Members of the group form friendships and are connected in ways not possible in traditional care. As such, group prenatal care is a form of social support, which may buffer its members against the deleterious effects of psychosocial stress on birth outcomes. Recent expansion of the group health care model into parenting suggests an opportunity for greater longitudinal integration of the care continuum.

This book, a study of how a single innovation can transform health care, originated as an idea of its founder, Sharon Schindler Rising, to provide more effective prenatal care to her own patients. Centering has now spread to more than 400 sites across the United States. This
book provides an excellent review of the science, theory, practice, and evidence of Centering health care all in one place. We need more of this kind of transformative innovation in health care delivery to improve the health of our nation.

Michael C. Lu, MD, MS, MPH
Associate Administrator for Maternal and Child Health
Health Resources and Services Administration
U.S. Department of Health and Human Services
Bethesda, Maryland

Reference

Preface

We have chronicled the development of a model that is an alternative to what we consider to be the usual ambulatory medical care standard: one-on-one care in a closed exam room. The frustrations with our current health care system are legion. Too much of our Gross National Product is tied up in health care, but we continue to see disappointing results. The focus of this book is prenatal/postpartum/well-baby care. In our opinion this should be the major focus of health care today. Our most precious resource, our people, all begin as embryos, newborns, and young children. A family—yes, a village—is entrusted with nurturing this resource. Yet, the lack of social determinants of health in many of our communities has contributed to women often becoming pregnant with many personal health deficits—smoking, inadequate nutrition, poor management of medical and mental health issues—and they may also be dealing with the effects of racism, poverty, opioid addiction, and gun violence. Even women who have enjoyed privilege through much of their lives have real and perceived issues that keep them from being totally healthy and ready for parenthood. The longing for a support community is universal.

CenteringPregnancy® was piloted in 1993 to 1994 by Sharon Schindler Rising, a nurse-midwife who knew there must be a better way to provide care. She had spent 25 years working with women from all socioeconomic levels and found common concerns surfacing—concerns that needed more time to explore than was available in the short visits allowed by the system’s expectations. It seemed natural to envision a different way to provide care, and so she just started—moving forward with careful attention, but also confident that women in her groups would show her the way.

Charlotte Houde Quimby has been a friend and colleague of Sharon’s for more than 40 years. She, too, has taught students, cared for many women, and started an innovative midwifery care delivery service. She has led groups, marveled at the sharing that happens among women
and couples, and longed for a better way to change our health care system. Pairing together to write this book made sense and has been a dynamic time for us both.

This book is a mixture of solid content on CenteringPregnancy and CenteringParenting®, circles, facilitation and implementation, and lots of stories. Some of the comments are short and come from reflections shared by group participants; some are longer profiles of people we have interviewed. One of these, Mindy’s Musings, appears in several chapters as segments from a longer interview. We have boxed or italicized many of the comments to call attention to them and their origin, whether from patients served or from clinicians serving. To help represent to the readers what being in a group is like, we created a composite character, Ramona, and shared her pregnancy and transition into parenting. We also have brought to life Paul, a clinician who is a group facilitator.

The turtle has been important to Sharon for years. The turtle resides between the two worlds and has the important task of assuring safe passage of newborns into the world. It also “doesn’t make progress until it sticks its neck out.” We are using the turtle as an icon to identify stories that are contributed by group participants.

The book has three main sections. The first one is focused on the Centering model with Chapters 3 through 6 anchoring the CenteringPregnancy and CenteringParenting models. The second section has three chapters, one on implementation of the model and the other two on expansion of the model, including the need for interprofessional education. The third section explores policy, several research-funded studies, and an expansive chapter on international uptake of the model. Finally, we again look at health care with a focus on steps needed to continue to disrupt and transform. We hope this will give the reader vision and courage to move forward with possible change, clinical groups, research, or policy/advocacy work to further Centering Healthcare™.

We encourage all who want to find out more information about Centering Healthcare to visit the website of the Centering Healthcare Institute, Inc. The website outlines the process of exploring training and consultation options available and provides a contact e-mail and phone number to connect directly with a staff person: www.centeringhealthcare.org.
It has been our pleasure to work together and to touch base with the many who have shared their experiences and insights. We have focused on writing a book that contains many stories about real people and their involvement with the Centering model and its effects on the lives of patients, staff, and clinicians. We truly believe that this model has the potential to change health care and the health of communities. May the force be with all of us as we work for better care for those entrusting themselves to us and hope for more joy in our work as we continue to be present for ourselves, our communities, and our world.

Sharon Schindler Rising
Charlotte Houde Quimby
Acknowledgments

It has taken many years and the contributions of lots of people to get to this point in the implementation and dissemination of the Centering Healthcare™ model. Many people have generously given their time and expertise to provide support and current information on their experiences with CenteringPregnancy® and CenteringParenting®. We want to acknowledge them here and realize that the possibility of missing some is real, especially our numerous site group leaders and facilitators, who also have contributed much through the years.

We want to thank many people who have shared their thoughts about how Centering fits within the current and expanding health care system: Amanda St. Aubin, Amy Fine, Amy Picklesimer Crockett, Barbara Fildes, Cara Thompson, Carmen Strickland, Carol Brady, Carolyn Aoyama, Debra Keith, Elysia Jordan, Fra Na Reddy, Gail Phillips, Gary Oftedahl, Jessica Densmore, Judy Butler, Karen Shae, Kimberly Couch, Kristen Sublett, Loral Patchen, Margie Rickell, Mark DeFrancesco, Merry-K Moos, Michelle Gallas, Michelle Munroe, Misae Vela Brohl, Richard Gilfillan, Suzanne England, Theresa Willie, and Toby Furash, among others.

Several people gave considerable time either to writing specific contributions to the text or agreeing to extensive interviews. They are Amy MacDonald, Art James, Carrie Klima, Gillian Fynn, Karen Baldwin, Jacqueline Grant, Jocelyn de Sena, Judy Levison, Katsie Cook, Kristin Vander Griend, Lisa Kugler, Margy Hutchison, Mari-Carmen Farmer, Matthew and Sarah Houde, Mindy Schorr, Paula Greer, Sarah Covington-Kolb, Sung Chae, and Sunshine Muse. We also had help from the Centering Healthcare Institute, Inc. (CHI) office, particularly from Tanya Munroe and John Craine.

We also acknowledge input from several students, including Carolyn Kieserman-Shmokler from the University of Wisconsin and Jessica Lyden, Julie Rivo, and Priscille Schettini from Duke University.
Acknowledgments

Through the years there have been many people who have given special leadership, most notably through CHI. The founding board and early leaders who contributed substantially include Catherine Hamilton, Carrie Klima, Gina Novick, Lois Daniels, Colleen Senterfitt, Deborah Walker, Doug Laube, Karen McGee, Peter Bernstein, Kelli Viscounte, Ben Doolittle, and Vera Keane. Janet Ray was the anchor in the CHI office for several years and Becky Lindsay provided early graphic designs and content for grants.

We would be remiss for neglecting to name the group of CHI faculty and consultants who, in recent years, have worked with sites and taught others about facilitation skills and model implementation. These individuals are Amy MacDonald, Barbara Winningham, Beth Monahan, Carrie Klima, Charlotte Houde Quimby, Claire Westdahl, Cynthia Wade, Deena Mallareddy, Gail Phillips, Genie Rotundo, Gillian Fynn, Jane Ann Fontenot, Kathy Trotter, Laura Wise, Laurie Jurkiewicz, Lynn Scheidenhelm, Margaret Taylor, Margie Rickell, Margy Hutchison, Mary Alice Grady, Misae Vela Brohl, Peg Dublin, Sharon Matlock, and Toby Furash.

We owe special thanks to two friends who have helped with editing: Marjorie Smith and Kathy McAdams. We owe a big debt of gratitude to Ron Rising for his support through the years, but particularly for his help with pictures, illustrations, and other details necessary for this book.

And finally, we thank Elizabeth Niegsinki and Rachel Landes from Springer Publishing Company for their help and encouragement.
Charlotte’s Story

I came of age in nursing as a maternity nurse, working in Labor and Delivery in Maine in the 1960s when women received enormous doses of medication to dull the pain and reduce the memories of painful labor. The privilege of attending their births never waned. Being witness to the work, the pain, and the joy of watching them welcome their new infants validated for me that this was where I belonged. This was also a time of burgeoning upheaval in women’s rights. Women were making decisions about childbearing and demanding to be awake during their labors and that their husbands be allowed to attend their births. As a young mother myself, I agreed: There had to be a better way. Midwifery became that way for me. At the Yale Graduate School of Nursing, I was blessed to have Sharon Schindler Rising as a mentor, and the millions of questions I had stored up began to have answers.

I stayed on at Yale to teach midwifery and work in a faculty practice. One night, on my way down the stairs to dinner, I met a young pregnant woman walking up the stairs, in obvious pain and out of breath. I learned that she had been contracting all day, had received no prenatal care, and was so frightened of elevators she was climbing the several flights to Labor and Delivery. She did not want her baby’s first touch to be filled with her fear. When I shared this story with the midwives, one midwife said she had noticed that many of the young women we were caring for had received no prenatal care. She had begun keeping track of their addresses and realized they were coming from the same geographic area, a section of New Haven, Connecticut, known as Fair Haven, the home of our new young patient. We reached out to the community and found a nascent clinic, meeting one afternoon each week in the community elementary school, with volunteer nurses and doctors. No one was providing prenatal care yet. We contacted the clinic about providing care to pregnant women and had the joy of developing a prenatal clinic within the Fair Haven Health Clinic.
In the late 1970s, I joined a young physician in his new private obstetrical practice in New Haven. I loved and laughed with the women as they brought legal pads filled with questions to their appointments. We worked to get through their lists, seldom getting past question two or three. I wanted more time with them. I wanted to understand the context of their questions. I wanted to know what their partners were thinking.

I had begun to understand the power of groups in graduate school, and wondered what it would be like to bring couples together in groups to talk about their questions. What themes would emerge? What was really happening in their lives? We began to offer Transition to Parenting groups, six semistructured sessions for couples in mid-trimester, co-facilitated by a nurse colleague who had experience and insights about groups, to explore the experiences of couples as they moved through their pregnancies. Soon, women who were not our patients were calling the office to ask, “Is this the practice that has a group for pregnant couples to talk about what is happening?” We knew then that we were right: Women and their partners had concerns, questions, joys, and fears that they wanted and needed to talk about. We catalogued the themes over several years and it became clear the themes were heartfelt and universal: ambivalence about being pregnant; fears of not being capable, or of something being wrong with the baby; issues of the partners about money, work, and sharing their partner; dissonance between their desires and what they were hearing from the experiences of their parents or relatives; and planning for the baby, from naming to care after birth.

The sessions were rich in information that made me a better midwife and solidified my belief in offering groups for pregnant women. Couples frequently maintained the relationships with one another and with me for years after. My belief in offering pregnant women groups was solidified.

In 1983, as my own family began to move into their adult lives and I had adjusted to being a widow, I moved to New Hampshire to develop a new midwifery service at Dartmouth Hitchcock Medical Center (DHMC).

In 1990, I received a call from the American College of Nurse-Midwives asking me to do a site evaluation of a family-planning project in Senegal. I loved working with the midwives there, and my strong desire to do international work was rekindled. That trip led to 10 years
of working with midwives in Africa, Vietnam, and Indonesia. My new husband and I spent a year in Uganda, where my work with a women’s health collective led to many circle sessions under banyan trees, talking with the women, watching them sew goods to sell for their new business ventures, and hearing their questions while they talked about HIV/AIDS, contraception, raising teens who were beginning to be sexually active, and their fears of vaccinating their younger children.

During this same time frame, Sharon began to develop the model for group care that became CenteringPregnancy®. It made so much sense. I attended an early CenteringPregnancy workshop and I was completely hooked.

I worked as a site approval visitor for the Centering Healthcare Institute, Inc. (CHI), consulting with sites as they implemented this model. Over and over, sitting in the circle, I was moved and inspired by what I saw. I knew that as a midwife in traditional care, the women I cared for received good care. But as I participated in a group at each of the sites I visited, I realized again how much more the women gained by being in Centering groups, hearing one another’s experiences, and learning new ways of thinking about pregnancy, birth, and parenting. I watched two midwives in an urban clinic cook traditional African food for their teenaged mothers-to-be; I saw male physicians in the South engage prospective teen dads in a way that made them want to be good fathers; I joined a group of Centering staff as they held hands and gathered in silence before beginning a group. I am very grateful to Sharon for her vision and for the privilege of sharing this journey.

A great deal of energy and attention is now being directed to changing and improving the health care system in this country. I believe the CenteringPregnancy model holds the promise needed to provide care that addresses better relationship-centered health, empowerment of women, and stronger communities. We hope it will make sense for you as we share our experiences and our learning about this wonderful model, Centering Healthcare™.

Charlotte Houde Quimby, MSN, CNM, FACNM
Strengthening of family values, preventing crime, and reducing violence are concerns that involve every American today; we are all looking for ways to achieve these goals. One untapped resource—perhaps the most important one of all in our search—is in the thoughts and hopes of women who are pregnant.

It has been well documented that pregnancy is a time of introspection and projection. During the months preceding her baby’s birth, each woman undergoes a psychological as well as a physical metamorphosis. She reflects on her own growing-up years and her direct experiences in being “parented.” Out of these perceptions, she builds an image of the kind of mother she wants to be. This process of decision making, with readiness to change, gives her a new chance to mature and use everything within herself and her environment to help her move into the maternal role. Obviously her mate, family, and friends can strengthen this process, as can those who are involved in her care.

However, our traditional system of prenatal visits focuses on physical progress and detection of “what might go wrong.” Little advantage is taken of the repeated opportunities to help the woman along in her maturation. On the contrary, many of the procedures and counsels offered during prenatal visits may undermine her self-confidence, create distrust of her own body and her ability to cope, and may even foster within her feelings of being in the grip of powerful forces beyond her control.

Sharon Schindler Rising’s system of care, on the other hand, by “centering pregnancy,” puts emphasis on the woman who is pregnant, not just on the pregnancy. Each woman is an individual within a group that shares the bond of being pregnant at the same time. In this climate of mutuality, the group and its leader can help each member to understand what is happening, and to feel confident that she has the capacity to deal with events as they occur. The expectation that her pregnancy is progressing well is continually reinforced. As a result, each woman can recognize that while all is not within her control, some of it is!
The parent who starts out with faith-in-self and confidence in her own coping skills is going to handle the tasks of parenting differently than an uncertain, fearful person. The impact her behavior will have on the guidance and rearing of children can only be imagined. But, multiplied many times, it may be the lever that can turn society around! Sharon is showing us the way. In implementing this model we may, over time, change the world!

Vera Keane, MA, CNM, FACNM
Cheshire, Connecticut
July 1995. Published as part of the Foreword to the first CenteringPregnancy handbook
Comments From Carmen Strickland, MD

Centering has quite literally changed my life. Let me share some of my treasured lessons:

**Stay Centered**

It is easy to lose focus in providing care. We can’t be there for the patient if we are not present ourselves. I’ve learned to take the extra minutes to center myself before any clinical encounter. I’ve also tried to implement this concept in my personal life although it is definitely a work in progress.

**Stay in Conversation**

Also true both inside and outside of care, the circle allows and promotes conversation. As we get busier and more automated, we become disconnected from our patients, colleagues, and friends. We are forgetting how to listen. Centering has shown me how valuable minutes can be if we use them to be in conversation with each other.

**Trust the Group**

By extension, trust the patients. As a clinician, I’d like to think this occurs automatically. Centering has shown me time and again the ways in which we undervalue the patients’ role in their own care, without even recognizing it. I have witnessed countless benefits that result from empowering the patients. By trusting our patients, we support them in
community building and expand their capacity to reach their fullest potential.

It is my sincere hope that more of the health care system will come to know and appreciate the simple but powerful wisdom that Centering has to offer. Think of what might be possible!

_Carmen is associate professor of Family Medicine, Wake Forest University._
_Shed is the chairperson of the Centering Healthcare Board of Directors._
Why do we limit ourselves so quickly to one idea or one structure or one perspective. Why would we stay locked in our belief that there is one right way to do something. We need more eyes to be wise. We have been invited to be part of the generative dance of life.—Margaret Wheatley (2006, p. 73)

This chapter explores the three CenteringPregnancy® group care components and the defining essential elements. In addition, it provides a visual representation of how group care actually works, discusses the space needed for CenteringPregnancy groups, and ends with a description of a CenteringPregnancy model designed for women with HIV.

What Is CenteringPregnancy?

And the day came when the risk to remain tight in a bud was more painful than the risk it took to blossom.—Anais Nin

Picture the current model of prenatal care. There are an expected number of visits, between 10 and 14, for the pregnant woman, starting in the first trimester and going through a postpartum visit. Initial intake may take more than one visit and include the following: nursing history, insurance assessment, laboratory tests, genetics testing, and enrollment in supplemental programs, maybe even a prenatal class. Then a return visit includes a physical exam and determination of risk status. Once in the system, the woman is scheduled for visits once a month for about 4 months and then every 2 weeks, or more frequently, depending on the medical monitoring needed.
A midwife arriving for a job interview sat in the prenatal clinic next to a woman who was waiting for her prenatal visit. The midwife, sitting in her heavy, winter coat noticed the clearly pregnant woman looking at her and then heard her say, “I see that you are here for your first prenatal visit. That’s good because they will check you over to be sure that you are starting a healthy pregnancy. But then take it from me, don’t come back until you are ready to deliver because nothing happens in the rest of the prenatal visits!”

These return visits become a routine consisting of collecting basic health data, a quick visit with the clinician, and any follow-up testing needed. Clinics struggle to have this time move efficiently, and clinicians find asking and answering the same questions over and over to be tiring, even boring. Patients experience crowded waiting rooms and rushed individual visits. It’s no fun for anyone. No wonder clinicians talk about burnout and patients skip visits.

Centering goes beyond standard definitions of prenatal care by promoting the concept that bringing women together in groups for care is quintessentially relationship-centered and honors the basic assumptions (see Chapter 2). The Pew-Fetzer task force report reinforces this concept by declaring that “the importance of the interaction among people is the foundation of any therapeutic or healing activity” (Health Professions Education and Relationship-Centered Care, 1994, p. 11). It further identifies relationship-centered care as “the vehicle for putting into action a paradigm of health that is focused on caring, healing, and community” (Health Professions Education and Relationship-Centered Care, 1994, p. 47).

There are many relationships within the care setting: (a) provider to patient, (b) provider to family, (c) provider to self, (d) care team to one other, and (e) patient to patient. In CenteringPregnancy the patient-to-patient relationship is at the core of the group cohesion and
community building that supports and nurtures women through the childbearing experience.

I debated whether or not to put Sara in group. A recovering heroin addict, living in a residential treatment facility? How would the others react? I assured Sara she wouldn’t need to share her story and invited her to join. People were startled when she blurted, during a discussion on nutrition, “They never give us fruit,” but eyebrows really went high when she commented later, “We have lights out at 10.” Before long, I heard “prison” being whispered around the circle, and I asked Sara if she’d be willing to tell her story. She explained everything—in vivid detail. As she finished, one of the women asked, “How do you get here?” “I take the train.” “Let me and my husband drive you today.” I don’t worry any more whether a particular women will “fit” in a group—I know enough now to trust.

CenteringPregnancy is relationship-centered care that provides opportunities for a pregnant woman to interact meaningfully with her clinician, other women, her family, and her community (Klima, Norr, Vonderheid, & Handler, 2009; Massey, Rising, & Ickovics, 2006; Novick, 2004; Rising, 1998; Rising & Jolivet, 2009; Rising, Kennedy, & Klima, 2004; Rotundo, 2011/2012; Tanner-Smith, Steinka-Fry, & Lipsey, 2012). This care engages each woman and provides extended opportunity for her growth and development as a mother. Physiologic care monitoring is done in conjunction with the same clinician along with the opportunity for women to engage directly with their charts. The publication, “No Decision About Me Without Me,” came out of the CenteringPregnancy’s work in the United Kingdom that encourages responsible decision making by both the woman and her clinician. This wisdom is reflected in Centering care (Gaudion & Menka, 2010).

“The providers didn’t just give you medicine and not tell you what was wrong. Even if they tried to do that you had a chart there that told you what was wrong.”

Relationship-centered prenatal care, the foundation for CenteringPregnancy, provides standard health care and, equally important, provides for interactive learning and community building. This design
ensures that care includes all the usual assessments and occasional interventions as needed to help ensure the best possible outcomes for the mother and the baby. The exchange of information and conversation occurs in a format that is fun and that encourages open dialogue among all the members. To further support this effort, there is time within the group for participants to get to know one other. This structure leads to a building of community that may continue long after the pregnancy has ended. All three of these components of care—health care, interactive learning, and community building—happen within the group setting with a stable cohort of women who stay together through the 10 sessions of prenatal care.

Three Components of CenteringPregnancy

CenteringPregnancy has three major components: health care, interactive learning, and community building. Essential elements help to define each of these components. Fidelity to the model’s structure is critical to its success (Novick et al., 2013). The elements below are specific to CenteringPregnancy prenatal care but equally applicable to any health population. They are also used to describe CenteringParenting® in Chapter 5.

**Health Care**

**Health Assessment Happens in the Group Space**

Within the group space is a private area for brief discussion between the woman and her provider; the actual belly check is done on a low table or mat. Music playing in the room enhances the privacy of this encounter. During this time, the clinician and woman review her health data and discuss any problems of a personal nature. General questions are brought to the group since many women are likely to have the same concern. This is what is viewed as the billable component of prenatal care since each woman has her own private assessment with the clinician.

One woman reported decreased fetal movement so we went down the hall to do a non-stress test. I asked two moms to bring her some sandwiches and juice. When I finished belly checks, I went to check on them. The test was reactive, and the three women were talking and relaxed. I said, “I’m glad the food made the baby perk up; you have passed the test.” She replied, “Oh, I haven’t eaten yet, we’ve just been talking!”
Women Are Involved in Self-Care Activities

Each woman collects her own health data including weight, blood pressure, and gestational age. These data are recorded by her in her chart, electronic or paper, and also on her own progress record found in her CenteringPregnancy notebook. Each woman also has access to pertinent chart information, including results from lab and ultrasound testing. Before the formal “circle-up,” she completes the self-assessment sheet for the session and revisits personal goals.

“I learned to take my blood pressure. I thought only doctors could do that.”—A teen mother

There Is Ongoing Evaluation

The site has set benchmarks for improvement and has a system to collect and record health outcomes. Regular view of their data assures the site that outcomes are improving through use of the group model. Data are also sent to the Centering Healthcare Institute’s (CHI) CenteringCounts™ data system (or other central data bank) at regular intervals. This helps maintain site approval status with CHI and contributes to the aggregate data set maintained by this national organization. A minimum data set includes such items as number of group sessions attended, delivery method, baby gestation and birth weight, breastfeeding initiation, and return for postpartum visit.
Interactive Learning

Groups Are Facilitated to Be Interactive

Once the health assessment has been completed, participants join together in an open circle for discussion. The clinician and co-facilitator sit apart from each other in the circle. A circle opening such as, “Share one fun thing that happened to you this last week,” helps start the discussion. Facilitators refer questions back to the group and encourage women to share from their own experience. Interactive activities help to discourage didactic presentations. Facilitators draw on the wisdom of the women in the group, sharing from their own expertise as appropriate. Training sessions for all staff and providers who touch the group are essential to model skills needed for active

“Group was a lot more enjoyable than sitting in a waiting room. We had personal, private time with the midwife and then shared our experiences, questions and concerns in group. I enjoyed being able to discuss discomforts and not being the only one experiencing them. I loved how personal our experiences became with one another. I learned so much. I will miss my group.”
listening. Facilitators also need to develop comfort with interactive strategies that encourage meaningful sharing among group members.

**Groups Are Conducted in a Circle**

To facilitate sharing and the ability to perform activities that may involve movement, the group meets in an open circle with no large table in the middle. Seating should be comfortable, either in chairs or on pillows on the floor. The space should be private, ideally with natural light. All people in the room should be seated within the circle so no one is thought to be an “observer.” Extra chairs are removed so the circle has just enough seats. A circle “center” is encouraged to help focus attention. This could be a vase of flowers, a small table with a cloth and suitable centerpiece, or women could bring something special to them and place it in the center.

> “I liked getting to know other women and sharing different opinions, the help and advice we exchanged was beautiful. I liked this format of prenatal care.”

Informal sharing with the clinician.
Each Session Has a Plan, But Emphasis May Vary

Both facilitators complete a Facilitator Process Evaluation at the close of each session. This helps the facilitators to prepare for the next session with such content as where the facilitators should sit to maximize group sharing, content areas that need further discussion, activities that might promote better group cohesion and sharing, and particular concerns about any group members. Before each session begins, the facilitators review their notes from the previous session. Needed supplies for the group are gathered. All participants have written materials in their own language. Pictures are used in some groups to help facilitate discussion. Improvement of health literacy is seen as one of the goals of Centering Pregnancy.

Particular sessions may need some formal discussion of content (e.g., genetics screening and flu vaccinations). Although the women take leadership in the discussion, there are several content threads that run through the 10 sessions. These threads include nutrition, breastfeeding, safe sex, stress management, exercise, preterm labor, and gestational diabetes. The facilitators hold the safety of accuracy and knowledge for the content of each group.

There were several couples in the Centering group who had met for several sessions. The clinician was “on the mat” doing a health assessment for one of the group members when one of the members entered the room and promptly started to cry. The co-facilitator (a nurse) and the group members gathered around her. When the young woman got to the mat for her assessment she said, “When I came into the room and saw all those guys with their partners it really hit me that my fellow is in jail and won’t be there to be with me when the baby is born.” The topics for the day were put on hold so we could spend time talking about the importance of support and ways that the group could reach out to this woman. It again emphasized to me the importance of not being alone and the power that the group can bring to undergird its members.

Group Size Is Optimal for Interaction

Group guidelines in appropriate languages are posted in the room, and written materials are available with translations as needed. Confidentiality is discussed and forms are signed and stored at the site. When a new member joins the group, confidentiality is again reviewed. Personal information shared with the group, stays with the group. Each woman is encouraged to share within the group, but there is never pressure for a woman to disclose beyond her comfort level.
Group facilitators do not wear lab coats or carry cell phones or pagers. While they are responsible for the ultimate safety of group members’ knowledge, their behavior supports the concept that the women themselves are experts on what they need, have wisdom to share, and bring different perspectives to the group.

The optimal size for a Centering group is about 10 women. This number meets most productivity expectations and also provides time for each woman to share. Groups have been smaller than six and larger than 12 and have still been successful. Small groups generally aren’t cost-effective and may be more likely to lead to didactic presentations if the women are hesitant to contribute. Large groups will take more time for individual assessment and also decrease the opportunity for each person to share. If partners or support people are present, they add to the complexity of the group.

At the first session of a mixed group of women and their partners, a teen Hispanic dad said that he just couldn’t talk in a group. By the fourth session one of the other dads pointed to him and asked him to be quiet so he could hear directly from his pregnant partner. This was a real “coming out” for him.

### Community Building

**Group Members, Including Facilitators and Support People, Are Consistent**

The group cohort is stable throughout the many sessions. This isn’t a therapy group with tight boundaries, but the group sharing, the information exchange, and the building of community happen best with the same group in attendance. Most sites find that the cohort firms up at about the third session, but a woman who arrives late to care often can still be added if there is room in the group and the members agree. Studies find that women who received most of their care in groups reported the highest level of satisfaction and the best outcomes (Cunningham et al., 2016; Ickovics et al., 2016).

Many of our Centering groups have baby showers. Moms set the price and (like a secret Santa) buy a gift for the name they pull out of a hat. The English-speaking group prices usually are $5 to $10 while the Spanish group moms are much more lavish (could be $20 or more). The group leaders always have some extra items on hand in case someone forgets to bring a gift.
There is an opportunity in most groups for partners or support people to be part of the group. The woman’s support person should be the same from session to session. Children are not to be present during the formal “circle-up” since this is a special time of sharing for the women and children cannot be counted on for confidentiality. Group leaders are very conscious of the Health Insurance Portability and Accountability Act (HIPAA) regulations that include confidentiality standards. Many sites make special provisions for childcare during Centering sessions.

At the second session of my first Centering group a woman arrived, thumping up the stairs, carrying a heavy backpack. Her blood pressure was elevated and remained so at the end of group. I asked her to wait while I finished up so I could escort her to the labor triage area to be checked. “I’m going now,” she declared, getting ready to leave. “Do you know where it is?” I asked. “No, but I can find my way and I’m going to go now,” she harrumphed, shouldering her pack. One of the other women came up to her. “You’re in a group now. You don’t have to go alone. I’m going with you.” That was when I knew that group care was the way to go!

The continuity of care, provided by the same clinician and co-facilitator through the entire series of 10 sessions, helps to ensure that health care
standards are met and that content threads are woven throughout the sessions. The setting also has backup in the event of an unexpected absence of one of the facilitators. Professional students who are part of the group are committed to attend all the sessions and also have appropriate supervision.

**There Is Time for Socializing**

The third component of the model, community building, calls for women to have opportunity for informal discussion and connection. Having fruit or other healthy snacks available and encouraging informal exchanges before and after the circle-up time, contribute to this, as does requiring nametags for all participants at each session. At one of the later groups, women could be invited to share their contact information to allow for continued interaction after delivery. In some sites, women set up a blog or other contact system for staying in touch. Since there is a stable cohort of women who meet together for the entire pregnancy, women get to know each other, reach out to those who need special attention, and form friendship bonds that often continue long after the pregnancy ends.

“When my boyfriend and I made the choice to join the group we had no idea how beneficial it would be to us. We loved the hands-on instruction and group sessions where we found others were going through exactly what we were. But the main thing the group gave us was our newfound friends. My fellow Centering mommies and I have a Facebook chat that dates back to when our babies were born. If you were to look through the messages you will see that we literally talk 24 hours a day, 7 days a week. We talk about life, babies, development, and even poop! Our babies are 5 months old and last night we all met for dinner. My boyfriend and I are so grateful to have those ladies and their husbands in our lives and we owe it all to CenteringPregnancy.”

**RAMONA**

**A Visual of the Group: How Does It Work?**

Let’s imagine how care in CenteringPregnancy will look for Ramona. Ramona is in early pregnancy and receiving care at a community health center near her neighborhood. She has had her prenatal intake that included her medical
history, essential lab work, genetics testing options, and a physical exam. Her insurance status was reviewed and she was encouraged to sign up for Women, Infants, and Children (WIC).

The clinician and the nurse both encouraged her to join the CenteringPregnancy group that would be starting in 2 weeks for women with pregnancies of 12 to 16 weeks gestation. The staff said that she would be with 10 to 12 other women of similar due dates and would meet with these women for all 10 of her usual visits throughout pregnancy. The group takes 2 hours and starts and ends on time with no waiting in the waiting room. She is shown the group space and told to go directly there without stopping at the desk when she comes for her next visit in 2 weeks. Ramona thinks that not having to wait in the waiting room will be a welcome change. Most visits she waits for at least 30 minutes before being seen and then another 15 to 20 minutes in an exam room before her provider comes in and does a quick check.

Ramona now has arrived for her first CenteringPregnancy visit and she goes directly to the group room. A nurse (medical assistant), Louise, and a clinician, Jane, who will be her care provider throughout pregnancy, meet her there (midwife, physician, nurse). The room is attractively furnished with music playing and a table in the corner with food and water. She goes to a check-in table and joins two to three other women who also have just arrived and who are making their nametags. The nurse gives each mother a CenteringPregnancy notebook and shows each where to record the health data. She then shows them how to weigh themselves on the digital scale and how to take their blood pressure using a digital cuff. The women even help each other to get the cuff on easily. She is oriented to the body mass index (BMI) chart and helped to plot her current weight and height and set her own weight goal for pregnancy. The nurse helps each woman to use the gestational wheel to figure out her pregnancy weeks. Ramona is happy to understand the difference between weeks and months of pregnancy. Each woman then records all of her own data in her pregnancy notebook and also may record it directly in her paper or electronic chart. Ramona asked some questions about what her numbers mean and feels that already she has learned important things about her pregnancy.

The nurse, Louise, shares with them the other parts of the intake flow. They have a self-assessment sheet for each session in their notebook that will take a few minutes to complete. This activity provides Ramona with an opportunity to think about timely pregnancy issues. The sheets are personal for her, a tool to use with her partner and family, should she choose, and to share within the group . . . but there is no pressure to do so. The topics
include such areas as common discomforts, breastfeeding, family dynamics, comfort measures for labor, emotional adjustment, and baby care.

Each woman has her own private, short assessment including a “belly check” and fetal heart tones with the clinician. This is the time for both of them to share particular concerns, many of which will be discussed in the group since they are common issues. Ramona notes that even though this assessment area is in the group space, because it is off in the corner and the mat is low, it feels absolutely private to her. Jane, the midwife, talks with her about her health data and personal concerns and says that she will be her care provider throughout her pregnancy. Ramona says that she will like having the same midwife every time.

There is a circle of chairs in the middle of the room and the nurse encourages Ramona to find a seat, look through her materials, and complete the self-assessment sheet for the day. Other women are also getting settled in the circle. Ramona hopes that she will feel comfortable in the group and that she will become friends with at least some of the women. She looks at the snack table, noticing that there is water, some fruit, and cheese/crackers. She asks the nurse if they can have a snack and the nurse invites all of them to have water and some food. This just reinforces Ramona’s thoughts that this visit is very different from regular care and is starting out to be fun.

When all the mothers have checked in and been seen by the midwife, both the facilitators join the circle. They don’t wear lab coats and they don’t sit next to each other. Now there are nine other moms in the circle each wondering what will happen next. The midwife, Jane, welcomes them to the circle and asks them to find another person to talk with. In a minute, each mom will introduce her partner to the group. Since everyone has a name tag it is pretty easy to remember names and Ramona enjoys her partner, Ida, and easily introduces her to the group. Jane then goes over the general flow of the sessions and gives the women their 10 appointments that will take them to their due dates. The group meets at the same time and on the same day so this will make it easy for them to plan work schedules and childcare. The discussion around confidentiality is an important one and includes reasons why children should not be present during this talk time. There are group guidelines with reminders to shut off cell phones, to come on time, and to be respectful of each person’s contributions. Part of this discussion usually includes the potential for bringing dads, partners, and friends to the group, especially to ascertain whether the women would be comfortable with having men in the group. Ramona thinks about her husband, Dave, and hopes that he will come with her to at least some of the sessions.
Jane and Louise work together to facilitate the discussion and start by talking about the importance of setting goals for this pregnancy. The women open the goals sheet in their pregnancy notebook and set two or three goals for the pregnancy. Ramona thinks that daily exercise and regular time for relaxation are important for her. She also makes a note that she wants to make time each day for Dave. The self-assessment sheet for the first session, “My Pregnancy: What’s Most Important,” focuses on topics that are most important to the group members. All the women identify “eating healthy for pregnancy and breastfeeding” as major interest areas so that leads into a discussion of nutrition. As part of this discussion the group is encouraged to share what they know about diabetes and why healthy eating might help prevent gestational diabetes.

Ramona enjoys playing a quick game that focuses on healthy food choices and important decisions around smoking, soft drinks, alcohol, over-the-counter drugs, and other possible toxic ingredients. As each mom pulls pictures out of a basket, all of the women talk about why a choice might be affirmative or negative. Ramona agrees with the other moms that she still has some important things to learn about having a healthy diet and staying away from items that might be bad for her and the baby.

Before she knows it the time is up and the nurse and clinician invite the group to stand, hold hands, and repeat these words: “I am a strong woman; I will eat well to stay healthy; I will do it!” The members continue to talk with each other as they leave, and several grab another snack to take along.

After the group leaves, Louise and Jane finish up charting and talk about the flow of the group. How did it go? What would have made it go better? What should be planned for the next session? Both of them comment on their own feelings about starting another group. Although there was work in the setup of the room, seeing the mothers get to know each other was a major benefit. Jane also comments that it felt good not to be rushed but to have time to really listen to the concerns of the women.

**Space for Centering Groups**

Space for Centering should feel like “a nest,” a place to go to that feels safe, warm, comfortable, and private.

Imagine an ideal space. How big? It’s square, at least 25 by 25 feet and located near an entrance or the parking area for accessibility. The room has a pleasant color scheme with murals or appropriate pictures. Since the room is used only for groups, it doesn’t need constant setup/
takedown, therefore supporting efficiency of the model. There are windows with translucent curtains or other appropriate covering if privacy is an issue, and there is no window on the door.

There is a check-in area with a room for at least two women to sit and measure their blood pressure, a digital scale with an arm for weight check, and room on the table for any other materials such as gestational wheels, and so forth. The assessment area is in another part of the room. Here there is a low massage table or an inflatable mattress, a spot for the clinician to sit, and two large plants to provide privacy. The clinician sits or kneels at the level of the patient. There is music playing in the room to provide both atmosphere and white noise.

The majority of the room is composed of an open circle to hold up to 24 chairs or pillows. The middle of the circle is bounded by a round rug that frames a centerpiece that may change from session to session and could be flowers, a candle, a visual that pertains to the main focus of the day, for example, a plate of healthy food/snacks, a pedometer (some sites give one out), a large birthing ball, or perhaps a baby blanket. The two facilitators take seats across from each other and may decide ahead
of time next to whom they should sit. A soft chime indicates the start of the group discussion.

The space also has room for storage of essential materials used in the group. Women are asked to freely offer questions and comments about their deepest worries as well as personal joys. Perhaps these are words they have never before shared with anyone. Group members often share their feelings of depression or inadequacy as a person or a parent, issues of interpersonal violence, cultural isolation, and fears about coping with labor or breastfeeding. The group provides each woman with a safe place to listen, develop strategies for herself, and test out her cultural beliefs without fear of being misunderstood. Peter Block notes:

*Community is built when we sit in circles, when there are windows and the walls have signs of life, when every voice can be equally heard and amplified, when we all are on one level.* (2009, p. 151)

In the initial pilot of Centering, it was clear that women were very satisfied to get care in CenteringPregnancy groups. “The combination of satisfaction, good outcomes, and effective delivery of care makes this an attractive model for agencies to implement” (Rising, 1998). Many studies of the model have continued to document high satisfaction of women and clinicians with the model (Baldwin & Phillips 2011; Earnshaw et al., 2016; Grady & Bloom 2004; Ickovics et al., 2007; Klima, Norr, Vonderheid, & Handler, 2009; McDonald, Sword, Eryuzlu, & Biringer, 2014; McNeil et al., 2013; Teate, Leap, & Homer, 2012).

**Mindy’s Musings**

We did the exercise where everyone writes down one thing from their family of origin that they thought was great and one thing from their family of origin that they did not think was great; everybody scrunches the paper, throws them on the floor, and popcorn style people pick them up and read them. Group consensus decides if it is going into the waste paper or this lovely other wicker basket. So most pretty cut and dried, there isn’t a whole lot of conversation about it. Then someone uncurled this piece of paper that said, “My mother was more my best friend than my mother” that the group did not find so cut and dried. There was a lot of conversation about it, the group decided to toss it into the trashcan. There was another thing that talked
about competition, to not bring so much competition among the siblings and to make their child so competitive. There was a woman who defended this as a great thing. The fact that there was a competitive spirit brought to her family made her feel like she was compelled to be the best she could be. And then one of the men said, “I so did not want to do this when my wife signed up for it, and I am so glad I did.” He said his father brought competition to his children in everything as he grew up. He feels that he can never do anything well enough. He has talked with his wife about this and he is very worried that it’s a legacy he is not going to know how to break. Now, what place in traditional care could a man say that? There is no room for men to process their concerns about parenting in traditional care. If we don’t think these discussions impact family well-being, we are mistaken.—Mindy Schorr, MSN, CNM

Special Challenges

Pregnancy has always been a time of challenge, joy, and change. But few other eras have presented the challenges we see today faced by parents in the first part of the 21st century: new and strange illnesses such as HIV and Zika, underemployment, discrimination, food and housing insecurity all piling on top of the usual concerns facing young families (Gordon et al., 2016). New approaches are needed to be confident, supported 21st-century parents, not focused on fear but on possibility. CenteringPregnancy provides the opportunity for parents to explore their deep concerns and receive validation as well as concrete solutions that will help them navigate these new waters. The following reflection describes one such group model focused on the particular health issue of HIV and pregnancy.

Reflections From a Clinician: CenteringPregnancy and HIV

Judy Levison, MD, MPH

Dr. Judy Levison recalls being at a CenteringPregnancy workshop when it was like a “light bulb went on . . . and I got it! If women attend all the Centering sessions, they will get what they need to know. We realized we had at least one HIV-related topic we could introduce into each of the 10 sessions.”
Groups were started in the fall of 2013. During the second year, the program got a nutrition grant from the Harris County Hospital District Foundation to purchase ingredients for healthy snacks such as peanut butter and banana sandwiches; black bean, corn and red pepper salad; and vegetables in a yogurt-based dip. With this grant, the program could provide a snack with its recipe at each visit, the women could take ingredients home with them, and they got a cookbook at graduation. One woman said, “I never would have bought red peppers before.” Judy prepares the snack ahead of time and laughs, “How many people can say their obstetrician cooks for them!” Starting in 2016, the local food bank is partnering with them by providing 30 to 40 pounds of fresh produce combined with shelf-stable items such as peanut butter, canned chicken, lentils, and whole grain pasta.

One of the important outcomes of the group is to make sure that the women are actively involved with their primary care clinician when the pregnancy ends. An asset will be the establishment of CenteringParenting, which will keep the groups together for another 1 to 2 years. Judy says, “In traditional care our HIV positive women define themselves as having HIV, but in Centering groups women define themselves as being pregnant and, by the way, having HIV. I couldn’t think of a better outcome.”

Judy Levison, MD, MPH, is a professor in the Department of Obstetrics and Gynecology at Baylor College of Medicine in Houston, Texas.

Here are two stories that help with further understanding the power of the model. The first is told by a midwife who facilitated this group. The second is told by the mother herself.

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**From a Group Facilitator: Monica’s Centering Experience**

Monica and her husband moved to our state from Honduras, found jobs and a place to live, became pregnant, and joined one of our CenteringPregnancy groups.

They planned to send money home and finally bring their other two children to the States, but Monica lost her job and her husband left her. During a discussion on support, Monica explained that she was living with strangers and our group was her only support.

Unbeknownst to the midwife, the women in group decided to have a surprise shower for Monica at our next session. They arrived at that session with a lovely stroller, other small gifts, and some cash, only to learn that Monica was in the hospital with pregnancy complications. After group, they packed up their shower supplies and carpooled to her hospital room.

Following the birth of her healthy, full-term baby, Monica became roommates with one of the other single moms in the group, who also found employment for her at her workplace. The group saved Monica.
Emily’s Centering Experience

“I was surprised to find that sharing such an intimate experience as pregnancy with a small group of people was more comforting and holistic than I had anticipated. It took more than one session to feel comfortable and at ease with the group dynamic, but we gelled and it worked and I can’t imagine not having had that experience now. We laughed and cried together, we shared pieces of parenting and labor experiences, we gave each other positive encouragement and well wishes to find what worked for us as individuals, and it was incredible. It felt good to feel like I had a group of people in my corner. I wasn’t just a name on a file, and I wasn’t waiting by myself in an exam room, I was with real people who shared pieces of themselves with me for almost an entire year.”

These stories demonstrate a strong alternative to the traditional care model that has driven our health system as long as any of us can remember. It presents an answer to many of the issues raised in Chapter 2. Mother/baby health outcomes are far from what we should be seeing despite the investment of enormous dollars. CenteringPregnancy data affirms that this model of group prenatal care will do just that—better outcomes for lower cost. “What’s the question? Centering may be the answer!”

References


As human beings, we are meant to be in conversation with one another. In circles, we share our stories, surface solutions to our challenges, and form bonds of strength that guide us as we continue our lives.

In this book, we explore a model of care that is revolutionary because it is counterintuitive to the accepted individual care model found in almost all of today’s health settings. The journey has involved over 20 years of experience with CenteringPregnancy® sites in almost every state with growing international activity. Affirmations for giving and receiving care through Centering circles continue to be expressed by most everyone exposed to this powerful model. So, how do we move what is widely recognized as a viable alternative model of group care into the mainstream so as to become the “this is the way we do care” model?

This final chapter explores issues raised in previous chapters from the perspective of how to integrate Centering Healthcare™ into the dialogue of health care reform.

In their book, Unraveled: Prescriptions to Repair a Broken Health Care System, Weeks and Weinstein declare:

We have incredible technology and have made major strides in applying that technology. Providing high quality care is so much more . . . understanding the whole patient, his or her values, environment, wants and needs. (2016, p. 4)

Weeks and Weinstein go on to urge a consumer-oriented health system calling on providers and consumers to drive an “industrial revolution” in health care.
As we begin our discussion in this chapter, we urge readers to move from the frozen spot of now firmly engrained in us, to focus on what is about to emerge. To unfreeze our perception of what is and what is to come, we need to slow down and open up to new thoughts and insights that may be there, ready for our acknowledgment. In *Theory U*, which explores processes of organizational change, this level of paying attention is called *presenting*, where there is heightened awareness and connection (Scharmer & Kaufer, 2013).

You might consider asking yourself: What do you think will happen with health care over the next 10 to 20 years? What can you do right now to make a difference that may lead to a new emerging future for you and your community? Our hope is that the model described in this book will help to shape that emerging future.

### The New 10 Rules for Redesign

We have referenced, in this book, the seminal Institute of Medicine work, *Crossing the Quality Chasm*, published in 2001, which outlined both aims and rules for system redesign. In that document, one of the six aims is the core need for health care to be patient centered, which is defined as “providing care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (Institute of Medicine, 2013). In traditional short visits, the aim of customizing care is to ensure that the patient’s values guide all clinical decisions, which seems like an impossible task. CenteringPregnancy provides a setting that encourages discussion of these individual needs within an atmosphere of respect for differences. This nurturing environment surfaces opportunities for relationship-centered care leading to growth for both the clinicians and the women.

In 2016, the Institute of Healthcare Improvement (IHI) published an update, *10 New Rules to Accelerate Healthcare Redesign*, recognizing that it has been well over 10 years since the first rules were published and still there is need for health care redesign. As the 2016 publication says, “The 10 new rules provide ambitious leaders in healthcare with much needed fuel to take a leap. After all, you can’t cross a chasm with a few small steps” (Loehrer, Feeley, & Berwick, 2015).

In Table 13.1, we have taken these 10 new rules and matched them to some of the basic elements of the Centering model.
### TABLE 13.1 10 New Rules to Accelerate Health Care Redesign and Centering Care Model Design

<table>
<thead>
<tr>
<th>10 New Rules</th>
<th>Centering Model Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change the balance of power</td>
<td>✓ Patients and clinicians are centered in relationship</td>
</tr>
<tr>
<td></td>
<td>✓ Skilled facilitation supports the process</td>
</tr>
<tr>
<td>Standardize what makes sense</td>
<td>✓ Educational content allows emphasis to vary with group needs</td>
</tr>
<tr>
<td></td>
<td>✓ Care, interactive learning, and community building all happen in the group space</td>
</tr>
<tr>
<td>Customize to the individual</td>
<td>✓ Educational content allows emphasis to vary with group needs</td>
</tr>
<tr>
<td></td>
<td>✓ Facilitative leadership encourages exploration of cultural values</td>
</tr>
<tr>
<td>Promote well-being</td>
<td>✓ Participants share their own knowledge and experience</td>
</tr>
<tr>
<td></td>
<td>✓ Participants are involved in self-care activities</td>
</tr>
<tr>
<td>Create joy in work</td>
<td>✓ Clinician satisfaction documented to bring joy</td>
</tr>
<tr>
<td></td>
<td>✓ Participant satisfaction is contagious</td>
</tr>
<tr>
<td>Make it easy</td>
<td>✓ Group process promotes trust and openness</td>
</tr>
<tr>
<td></td>
<td>✓ Making group care the standard of care maximizes routines</td>
</tr>
<tr>
<td>Move knowledge, not people</td>
<td>✓ Participants have access to and track their own health information</td>
</tr>
<tr>
<td></td>
<td>✓ Services needed are brought to the group space</td>
</tr>
<tr>
<td>Collaborate and cooperate</td>
<td>✓ Interdisciplinary collaboration is fostered</td>
</tr>
<tr>
<td></td>
<td>✓ Steering committee guides internal and external processes</td>
</tr>
</tbody>
</table>

(continued)
TABLE 13.1 10 New Rules to Accelerate Health Care Redesign and Centering Care Model Design (continued)

<table>
<thead>
<tr>
<th>10 New Rules</th>
<th>Centering Model Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assume abundance</td>
<td>✓ Health assessment occurs in the group space</td>
</tr>
<tr>
<td></td>
<td>✓ Group process promotes trust and openness</td>
</tr>
<tr>
<td></td>
<td>✓ Patients share resources with other group members</td>
</tr>
<tr>
<td>Return the money</td>
<td>✓ Evaluation of outcomes reinforces multi-level savings for reinvestment in community health care</td>
</tr>
</tbody>
</table>


Table 13.1, showing the 10 new rules and supporting elements of the Centering Healthcare model, provides clinicians and leaders with assurance that the Centering group model is in alignment with broader efforts to redesign care. Following are some specific ways that four of these rules are applied in the Centering Healthcare model:

- **Change the balance of power:** Providers intent on change should be at the table in board rooms, design rooms, and financial planning boards; they need to talk to funders, researchers, and auxiliary groups. They need to be in any arena where decisions are made about space, funding materials, advertising programs, or social network platforms. If we believe that change is essential, we owe this commitment to be present to change the balance of power to ourselves and to those for whom we care. Maternal and child health advocates have politely waited in line to accept whatever crumbs are left; such waiting is no longer acceptable.

  In Centering Healthcare groups, the power balance is shared by the clinician/facilitator and the persons in each group cohort. Facilitation skills demand attentive listening and remembering that: It doesn’t matter what we don’t talk about; we are talking about what matters to the group.

- **Promote well-being:** This book offers examples of creative approaches to well-being such as teen mothers eating more nutritious foods, acknowledging they have learned to love spinach; a young woman and a grandfather struggling with their diagnoses of diabetes, but
learning in a group that they are not alone and, like others, that they can learn to manage. We have included compelling stories of families and providers who lived and worked with painful diagnoses about their infants and leaned on each other for support in ways that opened their hearts and helped them grow through these tragedies.

• **Create joy in work:** In these pages, we relate stories of how eager new health professionals are ready and wanting to provide quality care, but how quickly their frustrations rise. Several professionals tell about the pain, shock, and disappointment of having no time to hear patients’ stories; they tell of working with providers who minimize the trauma inherent in their roles as clinicians, or deny them of opportunity to express the difficulty of the lessons they are learning. When one resident says, “I love this model. The problem is that it’s the opposite of what I am being taught,” she is expressing frustration over the disconnect she feels. Some clinicians who have worked hard to master the knowledge base are reluctant to relinquish their domain to listen to the women’s stories. Yet these same providers face hours of seeing patients when they don’t have time to do more than the “belly check and fetal heart tones” and end their workdays tired, frustrated, and disillusioned. They deserve the opportunity to explore new options, receive quality training in the Centering model, and have exposure to colleagues who have rekindled their joy at work.

We have talked about the triple aim of better health, better care, and lower cost that has been widely adopted as a way to set and review metrics focused on improvement. We also are encouraged by the work of Bodenheimer and Sinsky on a fourth aim focused on improving the work life of clinicians and staff. The very real burnout experienced by care providers is likely to increase partly due to expectations for availability of the primary care workforce. The joy found by clinicians and staff in their Centering group work relates directly to this aim (Bodenheimer & Sinsky, 2014).

Joy is evident when Centering patients eagerly share their appreciation for not having to wait in crowded waiting rooms and instead, have opportunity to make new friends and have creative learning experiences. *We came at the same time and left at the same time and something happened the whole time we were there.* When partners are included, they also express gratitude for being in Centering groups at this important time of their lives.

• **Assume abundance:** We, as midwives, family nurses and medical practitioners, pediatricians and obstetricians, administrators, and
policy makers must learn to question the term “abundance” and how it and other resources are distributed in health care. We have learned that mothers and babies are seldom the priority for funding and space allocation in our high-tech health care institutions. Most often, our requests are the last to be heard. We need adequate space to provide care in a group as opposed to requests for expensive machines and technologies. In fact, we don’t need much technology at all to provide Centering Healthcare. We need to remember that we are the advocates for our nation’s precious resource: mothers and children.

“For many years, Americans have been dying at younger ages than people in almost all other high-income countries. This disadvantage has been getting worse for three decades, especially among women” (Institute of Medicine, 2013). We have expensive drugs, the latest in technology and equipment, the best trained scientists in the world, the most expensive care, and yet, and yet.

In the past two decades, money and energy have been poured into increasing access for prenatal care, yet better outcomes have not necessarily been the result. Missing in these developments has been a broader view of the needs of women for health care that addresses a continuum of issues that impact women from pre-conceptional care, obesity, chronic depression, education, and referral when needed for contraception and prevention of disease (Handler & Johnson, 2016).

We need a sense of abundance that comes from stretching our hearts. We need to walk in the shoes of the women we serve who have no money to pay the next rent, who have no food security, whose situation is complicated by not having grocery stores in their neighborhood, and who, if lucky enough, are working two part-time jobs to make ends meet. We need to act first and worry later. We need to bring ourselves to speak at every meeting in every venue. We need to stop valuing high volume and start valuing better relationships.

What does abundance mean in health care today and who brings it to the table? Our mothers in group bring their extra clothes and baby items to share, they sponsor baby showers for themselves, and they bring food to group and proudly share cultural recipes. They provide rides and childcare for one another and grieve with the mother and family experiencing loss. What abundance! “What made for change was communities that believed they had capacities, skills, abilities and could create power when they came together in a community—that
is how change happens” (Block & McKnight, 2009). Let our patients remind us of abundance and show us ways to tap into that energy.

These new rules for the acceleration of health care design should give us the courage to be strong advocates for a disruptive design for giving and receiving health care, precisely what is found in the Centering Healthcare model.

### Life Course

In an editorial titled “Toward a National Strategy on Infant Mortality,” Lu and Johnson remind the health community, “each stage of life is influenced by all the life stages that precede it, and it, in turn, influences all the life stages that follow it” (2014, p. S13).

The potential for empowerment and growth found in CenteringPregnancy raises these important questions: Would our outcomes be different/better if we used life course theory to ground our practice, research, and relationships within and outside of the health care setting? What would happen if the majority of our care in life happened in groups? Imagine more settings like the Mama Cares groups at Children’s Hospital of Philadelphia (CHOP) where women carrying babies with major defects talk together and families are welcome to be present, including at the time of birth. Such a program exemplifies caring for an entire family in ways that could have profound effects on the psychological life course of the adults and the children. The Healing Circle for staff at CHOP provides an extraordinary opportunity for all of the staff to share together deeply about their own experience with providing this amount of caring day after day. The Centering-like circle is a unique time for intimate reflection. This group sharing could make the difference in the ability of each person to continue the intense, personal work with grieving families, again affecting the life course of everyone involved. (See Chapter 8 for more details.)

Some years ago Rising developed Lifecycle Components of Women's Health Care, a model for exploring components across the life cycle affecting women from their time as young girls to old age. The components included sexuality, exercise, nutrition, substance abuse, safety, self-esteem, mental health, and interpersonal relations.

Each of these components is present throughout women's lives but may manifest differently at different times. For example, young girls work
on personal boundaries, adolescents on risk reduction, young women on reproductive issues, midlife “travelers” on menopause, and older age on physical challenges or bereavement. Time spent in Centering circles, 20 to 40 years before some of these important life components, can yield tremendous benefits for group members as life goes on—the benefit of listening and responding in wisdom and empathy to one’s children, family members, and oneself or each other as life unfolds.

Misae Vela Brohl, a nurse practitioner in Denver, tells of her experiences with her CenteringParenting® groups, some of which still are meeting yearly for their care and that of their growing children now 8 and 9 years old. Referencing one group, she says, “They have become a community . . . they are friends and their children are friends. They look forward to getting together . . . this is their support group.” It is possible to imagine the positive effect this long-term group experience is having on both the mothers’ and children’s ability to navigate the societal challenges concerning parents today.

Healthy People 2020, in addressing the social determinants of health (SDOH), has set a goal to “create social and physical environments that promote good health for all” (Office of Disease Prevention and Health

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Promotion, 2016). The five key areas/determinants are: (a) economic stability, (b) education, (c) social and community context, (d) health and health care, and (e) neighborhood and environment. Screening for these SDOH during the prenatal period will surface individual needs and more broadly, those of the agency’s population. By working to establish policies that positively influence these conditions, including those that encourage changes in individual behavior, it is possible to improve health for large numbers of people. These changes can be sustained over time leading to a healthier community for living, learning, working, and playing.

A powerful movement referenced by Thurow’s *The First 1,000 Days,* is working worldwide to provide enhanced nutrition to women, babies, and children during this critical time of development. “What happens in those 1,000 days through pregnancy to the second birthday determines to a large extent the course of a child’s life—his or her ability to grow, learn, work, and succeed” (2016, p. 7). The impact of poor nutrition early in life has lasting effects that can transcend generations. Women who grow up malnourished often birth girls who are low birth weight and who may grow up to be malnourished mothers. Many of these babies are born preterm or have low birth weight and become one of every four children in the world who is stunted. Strategies include a strong effort to increase breastfeeding and to enrich agricultural products with micronutrients. Evidence shows that with this focus on nutrition, more than 1 million lives can be saved and that individuals, communities, and countries can all be helped to rise out of poverty. This work is a fit for CenteringPregnancy and Parenting groups worldwide as they emphasize good nutrition, group support, and behavioral change.

Making successful, sustainable change requires that all members of the community look for ways to collaborate, and for most this will mean outside of the usual work areas. Perhaps one way to say this is that all members of the community need to be “present” to the issues affecting the population, looking for ways to bring personal and professional assets to the table. In one inspired implementation project, in an inner-city school in Washington, DC, the principal, David Palank, introduced Dialogue Circles, “Conversations in which participants make a conscious attempt to suspend their assumptions . . . and focus on individual and group learning” (Plank, 2015). As principal, he used the dialogue circle method and found it was a powerful tool for increasing generosity, trust, social connection, and cooperation among students.
Circles and Listening

Across the country, our children are experiencing toxic stress and increased family neglect, leading to poor educational and social outcomes. More and more children are in state custody. In Vermont, the rate for custodial care for the youngest and most vulnerable children, ages 0 to 5, more than doubled between 2014 and 2016 (Vermont Agency of Education & Human Services, 2016).

That means the social determinants for these families have been stressed to the breaking point. Decades of research support what we see: babies and young children who suffer early childhood traumas are more likely to be sick, to do poorly in school, and to develop behavioral problems in early grades. Unfortunately these children often are caught in interpersonal violence, drop out of school, and are incarcerated by the age of 17 (Centers for Disease Control and Prevention, 2016). The Centering models are designed to help young mothers learn skills, ask questions, and support decisions that begin to empower them to care for themselves and their children in positive and productive ways.

Benefits for Teens

The first evaluation study of a teen CenteringPregnancy model occurred at Barnes Jewish Hospital in St. Louis and was published in 2004. Outcomes included better attendance for prenatal and postpartum visits, improved health outcomes, and increased satisfaction of care when compared to teens in traditional care (Grady & Bloom, 2004). Trotman and other researchers in their study of adolescents also confirm better attendance, more appropriate weight gain, and increased commitment to breastfeeding. Of significance, there also was an increase in use of long-acting reversible contraception and decreased incidence of depression (Trotman et al., 2015).

What is also needed to protect the health and well-being of our young people is to provide food security, safe neighborhoods, excellent schools, gun safety, and restorative justice programs to prevent and reduce incarceration. In short, it means that now is the time for communities to be receiving the help they need. John Santelli, MD, chair of the Heilbrunn Department of Population and Family Health in the Columbia University Mailman School of Public Health, New York, New York, makes an eloquent case for this investment:
From a life course perspective, adolescents stand at the cross roads of the major challenges to global health: HIV/AIDS, intentional and unintentional injuries, sexual and reproductive health, and chronic disease. Investments in adolescent health have the potential to alter the future course of global health.

Why Do Centering Circles of Care Work?

We have opportunities to listen to stories in individual care, but the setting and time constraints make deep listening difficult.

More and more we are learning about the importance of stories, of listening and hearing and honoring the lives of those we care for. David Isay, the founder of Story Corps, tells us, “The soul is contained in the human voice” (2016). The act of being listened to can be revolutionary in people’s lives. Structuring an environment where each person can be heard and find his or her own voice provides a safe space for exploring each life and learning from one other. Such experiences can show each person how to live a better, more empowered life. There is growing interest in listening to the stories patients tell, such as in the Narrative Medicine Program of Columbia University, developed by Rita Charon, MD (Narrative Medicine Master of Science, Columbia University School of Professional Studies, 2016). This program brings together people from multiple disciplines to learn how health care is perceived by those who receive it, with tellers of stories ranging from speakers on racial disparity to those dealing with death and dying.

From 2005 to 2009, the Collaborative for Development Action (CDA) conducted a Collaborative Learning Project to listen to the voices of people in the countries receiving international assistance. Conversations were conducted with a broad cross-section of people from local workers to government ministers. Many people commented on how thankful they were just to be listened to in a way that reinforced the value of their ideas and judgments. This act of listening brought about “a fundamental shift in the relationship between the aid providers with aid recipients” (Anderson, Brown, & Jean, 2012, p. 146).

Stories and narratives can provide more insights for clinicians and researchers to understand the context of the patients’ lives and struggles. Woolf’s investigators are working to develop guidelines for gathering stories and a methodology for determining the stories’ importance in
clinical decision making (Woolf, Zimmerman, Haley, & Krist, 2016). This nascent movement toward the integration of narrative bodes well for CenteringPregnancy, where the premise of each group session is the importance of hearing each woman’s story as she shares it as part of the group process.

Providers are in need of the same kinds of sacred spaces—spaces where they might identify the ways their training obliterated or damaged their desire to heal themselves as they cared for others. Dr. Rachel Remen has developed a curriculum for medical students, “The Healers’ Art, Because Medicine is an Act of Love,” which is now offered at more than 70 medical schools (The Remen Institute for the Study of Health and Illness, Wright State University Boonshoft School of Medicine, 2016). The goal of Remen’s and other programs is to give medical students the opportunity to explore how to keep themselves well as they care for others.

Patients mine narratives from family members, friends, and the media when making health decisions in exam rooms, hospital rooms, and living rooms. (Dohan et al., 2016, p. 720)

“My friend called me and said that her clinician was encouraging her to have an induction of labor and she wasn’t sure that was a good idea. So I asked her, ‘What does your group say?’ She responded, ‘What group?’”

Human contact, such as smiling, making eye contact, and telling stories has, by these simple acts, the capacity to encourage people to work together. In The Moral Molecule, Paul J. Zak describes research which demonstrated that oxytocin, the hormone far more familiar as the agent responsible for the onset of labor or the release of milk in the nursing mother, can also be released by self-disclosure, an effect that is magnified by trust (2013a). This effect of oxytocin also makes the listener more inclined to trust. Zak’s experiments indicated that when individuals viewed an emotional story, they released oxytocin, making them more likely to donate earnings they were receiving from the experiment itself. “What we know is that oxytocin makes us more sensitive to social cues around us. In many situations, social cues motivate us to engage to help others, particularly if the other person seems to need our
help” (2013b). It begins to explain, then, the dynamic we have reported so frequently in this book: listening to another’s stories moves members of the group to reach out with support and understanding.

Researchers who are working to understand the importance of listening, hearing, quantifying the data from the narrative, have said it well, “Although numbers are powerful, stories trump numbers, and relationships trump stories.”—(Elwyn, Frosch, Volandes, Edwards, & Montori, 2010, p. 706)

Achieving Sustainability

There is considerable discussion in this book about the challenges of implementing a new model that is totally disruptive to the established system justified by, “We have always done it this way.” What is understood even less well is how to achieve sustainability, or the step after initiation, and the steps after that.

In the early days of watching and evaluating the effects of Centering on health outcomes and also the effect of Centering on systems, we suggested in our training workshops, “Just set this up as a pilot program.” This was a fine way to start with a new care model that still needed data for us to understand the challenges as well as the health outcomes. As more and more data arrived, it was clear that the model did lead to more satisfied patients and clinicians and better health outcomes and that it would need system resources for support. So then we said, “Establishing Centering as a pilot is like a bubble on the top of the system. What happens to bubbles?” Quickly people understood that to be successful, Centering needed to get into the mainstream of health care delivery.

A book that speaks to the need for sustainability is Stephen Lundin’s, Fish! Sticks (Lundin, Christensen, & Paul, 2003). Lundin wrote several books based on his experience with the innovation he witnessed at the Pike Street Fish Market in Seattle where a culture of fun and excitement pervaded the air, causing spontaneous energy to erupt. It is impossible to be passive when a big fish that you’ve ordered is being thrown to you! Fish! Sticks is focused on getting change infused into the fabric of the institution. It then becomes simply the way things are done.

The efforts for sustainability need to happen even before implementation of the model. There may be initial grant funding, but a line item needs to
be established that will ensure funding after the grant period ends. The steering committee's oversight will help to encourage continued buy-in across the agency. Patient members of this committee will be helpful in assessing the success of marketing and suggesting new strategies to enhance patient enrollment in groups. A plan for periodic training in group facilitation for new staff and opportunities for seasoned facilitators to improve their skills will help to ensure sustainability and continued satisfaction of staff and patients with the model. Disrupting the current care model is hard work. Make sure your new model will last by planning ahead for sustainability.

Heading Into the Mainstream: What Do We Still Need To Know?

Investing in prenatal care research must be part of the comprehensive prenatal care agenda. (Handler & Johnson, 2016)

“We know that it works but we’re not sure why it works” is frequently heard to describe our experience with providing care in Centering groups. Researchers, clinicians, and policy makers continue to look for answers; Centering sites are expected to collect at least a minimal data set. While it makes sense that providing care in Centering groups will lead to increased satisfaction of patients and staff, it doesn’t make sense to many clinicians that sitting in a group and listening will lead to a reduction in preterm birth, even though there is evidence that it does!

As we head into the mainstream, it is clear that more support in terms of research and hard evidence is needed to show that providing health care in circles makes for better outcomes. There is a continuing need for proof that providing care in circles where participants are heavily involved in gathering their own health data, setting personal goals, and sharing with each other around important life issues will actually be more beneficial than the current, short, individual visits with additional monitoring of the mother and fetus. True randomized trials are difficult, especially when patient choice should be considered. As group care benefits become more widely acknowledged and people experiencing care in groups share the benefits with their friends, it will be harder and harder to truly randomize.
Data continue to support several outcomes: reduction in preterm birth, increased breastfeeding (both initiation and continuation), increased uptake and use of efficacious family planning methods, and longer spacing between pregnancies. In addition, there is a better attendance at group visits, and group members report stronger support networks and more success at reaching personal weight goals, and greater satisfaction with care. Data from cost studies also is showing promising reductions in cost for group care. We are curious about what makes groups work, why outcomes are better, and what we can learn to make this model even more effective with greater uptake. A recent article titled, “Group Prenatal Care: Has Its Time Come? asks many of the key questions (Picklesimer, Heberlein, & Covington-Kolb, 2015).

Future Research Questions

We have grouped a collection of research questions under several headings: community focused, characteristics of excellence, life course benefits, health outcomes, and institutional benefits. And we have followed this with a discussion of qualitative themes that have emerged from several of the publications on the Centering model.

Community Focused

- How does the community building that happens in groups affect the community? Are group participants more involved in issues in their community that affect wellness and the social determinants of health?
- How are community-based services such as Healthy Start, Head Start, home visiting, and legal aid articulating with Centering groups to strengthen impact?

Characteristics of Excellence

- How many Centering groups have members who continue contact after their group care involvement has ceased and are there measureable outcomes from those that continue?
- What are the major factors at the site level that indicate potential for successful implementation?
- What are the characteristics of Centering sites that have achieved model sustainability?
- What processes internationally are related to successful implementation of Centering or CenteringPregnancy-based ANC?
Life Course Benefits

- What are the long-term effects on family nutrition when mothers have been involved in Centering groups? Is there a reduction in obesity, especially in the children?
- What are the measureable mother/baby/family outcomes in a longitudinal study starting with CenteringPregnancy and following through at least 2 years of CenteringParenting?
- What cultural issues are most relevant to group facilitation and how does culturally sensitive care in groups affect the participants?
- How do Centering groups fit into the life course theory and efforts to address maternal child health disparities?

Health Outcomes

- What is the effect of participation in Centering groups on stress hormones and is there a relation to preterm birth?
- Does participation in Centering groups serve as a mediator for depression?
- In a large multisite study, does the preterm effect hold and are there other outcomes we have yet to study?
- What are the differences in outcomes when dads are involved in groups?

Institutional Benefits

- What are the benefits and challenges of mother–baby dyad care for the dyad, the system, and the clinicians, and are these challenges worth the benefits?
- Do staff involved with Centering groups experience more job satisfaction and longevity at the site? Is there a measureable effect on the workforce?
- Do students and residents exposed to providing care in Centering groups transfer that experience to individual care and to subsequent professional work?
- What is the cost benefit of Centering care to the site, the providers, the larger system, and the insurers?
- What are the longitudinal benefits, such as reduced chronic care issues and increased family stability, that might be measured?
Qualitative Data: Themes

Then there are themes that have surfaced from the qualitative studies looking at physicians, midwives, and women’s responses to Centering care (Baldwin & Phillips, 2011; Herrman, Rogers, & Ehrenthal, 2012; McDonald, Sword, Eryuzlu, & Biringer, 2014; McNeil et al., 2012; McNeil, Vekved, Siever, Horn, & Tough, 2013; Novick, 2009). Some of these themes are:

- Knowledge is power: Women access information and use it with more confidence.
- Connecting and not feeling alone: Continuity with the clinician and with the same group leads to feelings of safety and support.
- Supporting each other: Women often reach out to others in the group and provide support through offering rides, sharing extra clothing or baby items, providing needed childcare, supporting another during labor, and so on.
- Respect: Women find they can share some of their most personal concerns with others who listen without bias and in an atmosphere of confidentiality.
- Reassurance: The comments, “I’m not the only one going through this” or “Someone would raise an issue that I had but was too embarrassed to ask,” speak to the power of the circle.
- Taking ownership of care: Women understand their health data and ask for test results. The discussions focus on what matters to them and result in confidence in their decisions. They learn what they should worry about and make appropriate calls for help.
- Getting more in one place at one time, fun: Women and clinicians laugh together, hold hands, give each other affirmations. All the care components happen in the group space.
- “I’m a better mother . . . I’m a better clinician.” All group participants seem to gain confidence, skills, and knowledge. These learnings become embedded in the behavior of the individuals and are seen in communication styles with family members or in interactions in individual care encounters.

While some might consider studies on these themes to be “softer” data, it is impossible to minimize the importance of these feelings of...
connection and empowerment to overall well-being, health, and joy at work. Many of these themes beg further study.

Most of the needed studies will require significant funding and cooperation among academic institutions, health care facilities, and other agencies. The requirement for indirect costs by each institution makes funding these studies costly and difficult. The military could be one excellent venue for a large group study that could more easily include randomization, possibly done by site rather than within sites and reduce concern about selection bias. Another avenue for collection of large data sets could come through the insurance industry and their claims data.

To maximize the impact of smaller studies, a decision to use particular validated and reliable surveys across studies could lead to confidence in the use of aggregate data. A recent review of group prenatal care studies compared to those from traditional care identified the lack of comparable tools for assessment of many outcomes among the studies to make conclusions difficult (Carter et al., 2016). A group of academic researchers could work with the Centering Healthcare Institute (CHI) to create a repository of suggested tools for use by a variety of researchers. A connection with government institutions such as the Agency for...
Healthcare Research and Quality (AHRQ) or private groups such as Westat could facilitate the work on these data sets. The CenteringCounts data tool of CHI also could be expanded to collect research data from sites participating in these larger studies. One review of Centering publications concludes: “Building consistent study results across a number of studies is needed and is the essential next step in developing this body of knowledge” (Manant & Dodgson, 2011, p. 101).

Summary: A Call to Action

Our institutions can only offer service—not care. We cannot purchase care. Care is the freely given commitment from the heart of one to another. . . . And it is this care that is the basic power of a community of citizens. . . . Our way is made possible by the power to care. (Block & McKnight, 2009)

We know the downstream/upstream story. We continue to work hard to fix the problems, some that result from the social determinants of health and others that result from poor health choices. One article referenced the I Love Lucy episode where Lucy and Ethel have jobs in the candy factory, wrapping the candy. At first it is fun, but as the conveyer belt starts to accelerate they can’t keep up. As Lucy starts eating the candy she soon winds up with, “a full mouth, full hands, and candy piling up.” She runs out of options. This is much like the downstream story we can relate to in our sites and communities today (Rising, & Senterfitt, 2009).

The work of Rachel Remen and the model for medical student education shared by Amy MacDonald both give us hope. The need for new ways of learning for our interprofessional students is absolute. These models demonstrate hope for new “cracks” in the system that let new light in.

More than a decade ago, pioneering nurse-midwife Vera Keane asked:

Just what makes life “better?” Certainly, good physical health is the most basic component. Centering provides ample opportunities in its construct for participants to check on and learn about their own health status and how to improve it. Centering goes far beyond that. Its structure fosters the personality development and mental health of participants through its nurturing, supportive and confidence-building approach. It is in this arena that Centering is sowing seeds of a revolution that could, over time, help more people to think about and deal with one another in positive ways. (V. Keane, personal correspondence, 2003)
Listening to each other and working together in partnership to make the needed changes in care is essential to bringing forth better care, better health, and lower costs. Verbiest and others call for a “new social movement to create an agenda for women's reproductive health and economic justice that will usher in a new period of health, social, and financial development” (Verbiest, Malin, Drummonds, & Kotelchuck, 2015, p. 741). We can maximize the power of groups by encouraging a focus on racial justice and equity.

The challenges to reform health care are legion and complex. We believe that Centering Healthcare already is responding to this challenge. The process of writing this book brought us into contact with people all across the country: clinicians, patients, administrators. . . . Listening to their stories reinforced for us what we already knew: this is a powerful, renewing way to give and receive care.

What is the question? Centering is the answer.

References


