LEADERSHIP CASE

CENTERINGPREGNANCY SOUTH CAROLINA

Amy Crockett likes to work where there are problems to solve: "My heart and my passion are with people who need me most; people who are dealing with challenges like: How do you keep your insulin cold if you don't have electricity or a refrigerator? How do you remember which bottle of pills to take, and when, if you can't read?"

As an OB-GYN doctor specializing in high-risk pregnancies in economically and socially disadvantaged communities, Amy has indeed positioned herself in a space where her work is all about solving problems—complex, systemic problems. The median age of her patients is 20; education levels are generally low; less than 15% are married. Many lack critical social support in both logistical and emotional terms, and pregnancy health outcomes are desperately poor. Whereas the US average for preterm births is around 10%, in South Carolina, where Amy works, there is an unusually high rate of 12.3%. Among African-American women, the rate rises to almost 18%.

> "CENTERING IS NOT HIGH-TECH—IT'S ABOUT WOMEN CONNECTING WITH EACH OTHER, AND HOW THAT SUPPORT CAN IMPACT THE GENE EXPRESSION IN THEIR PLACENTA."

"There are many racial disparities in health outcomes," Amy says. "It is the social determinants of health that lead to disparities. It's the environment that people live in, their level of education, income and job security and everything that happens in their life that make the difference." Reducing preterm birth figures—and reducing the racial disparity, which sets the pattern for lifelong disparities in education, health and employment—is what drives Amy.

As a physician, Amy is both powerful and powerless. "Problems are caused by things that happen well beyond what I can control in the 10 minutes that I'm with a patient," she says. When she first stumbled across the CenteringPregnancy model, she saw clear potential: "In Centering groups, we're able to address issues from all those other domains of patients' lives. We can really reach out and help with personal relationship problems, provide some meaningful education, listen to questions and concerns and address them in a relaxed atmosphere."

CenteringPregnancy found Amy, rather than the other way around. Initially, she was skeptical. It all seemed rather soft and fluffy. "There was research from Yale, a randomized control trial that had showed

ABOUT AMY

Maternal-fetal physician, nationally recognized for her research and leadership on improving the outcomes of high-risk pregnancies and reducing preterm births.

Amy's eldest daughter was born preterm, focusing her thinking on the consequences of preterm births.

Medical Director of the Greenville Health System Obstetric Center and Associate Professor at the University of South Carolina-Greenville Medical School.

Initiated CenteringPregnancy in her practice in 2009, and scaled the model across South Carolina in 2013.

A Liberty Fellow of the Aspen Global Leadership Network.

Winner of the John P. McNulty Prize in 2016.

improved rates of preterm births for women who had gone through Centering. That was in Connecticut and I thought, well that's nice, but this is South Carolina. I tried it anyway because I thought the patients would enjoy it, but I didn't necessarily believe we would see improvements in our health outcomes.

"About a year and a half later, I was shocked to see that we had better birth outcomes too, matching the data that had come out of Yale.

"And that's when I thought, there's really something to this. The patients loved it, my midwives loved it, and it was also giving us better birth outcomes, which is what really matters. So that was when I decided on my Liberty Fellowship venture to scale up the model."

CenteringPregnancy is founded on a structured but flexible framework. After initial private consultations with the doctor, patients join a group of up to 10 women who are all due to give birth around the same time. This group spends 10 two-hour sessions together during the course of their pregnancies. At each session, each woman takes her own weight and blood pressure measurements, a strategy to encourage patients to take responsibility for their own health; and each receives some personal attention. Thereafter, facilitated discussions take place that provide critical education, encourage patient activation, and foster social support for group members. Although there is a defined curriculum, there is flexibility to talk about what's important to the group, when it becomes important. "If on a day when you're supposed to be talking about breastfeeding, something comes up and it seems you need to be talking about domestic violence and interpersonal relationships, then you take advantage of that opportunity and meet the women where they are with the information that they want, when they want it," says Amy.

She shares an example of a group that contained, amongst others, two pregnant teenage sisters. Though one of the teens showed evidence of domestic abuse, she would not open up about it. One day, one of the older group members, a second-time mother, shared how she had found the courage to leave the abusive relationship that had resulted in her first child, now aged 11. This second pregnancy, taking place in the context of a loving, supportive relationship, was a profoundly different experience. "It was silent in the room while she was telling the story of the abuse and humiliation she endured previously. And these teenagers, in the middle of tumultuous relationships, sat with huge eyes, just absorbing it. And I thought: this is what they need. She reached those teenagers, by example, in a way I never could," says Amy.

In another example, Amy tells how, with the medical team struggling to find a baby's heartbeat, the mother left the room for an ultrasound check, which ultimately confirmed the baby was healthy. The group had been tense while they waited for news. When the mother returned she was emotional. She shared that the baby had been unplanned, and until that moment, she had been ambivalent about her pregnancy. "It opened up an important discussion in the group about the fact that not all pregnancies are welcome, and mothers often feel resentful, afraid and guilty about their own 'unnatural' lack of happiness."

For Amy, the decision to scale up CenteringPregnancy meant setting out to systematize the use of the model throughout South Carolina's public health system. Previously, the model had been adopted primarily in boutique midwife practices. Amy's vision for Centering as a public health solution was inspired—but getting the system to buy into her vision was a Herculean task. Initiating medical and scientific research was one thing, but persuading government and insurance bodies to provide financial reimbursement was another.

ABOUT THE CENTERING PREGNANCY MODEL

- CenteringPregnancy®, developed by the Centering Healthcare Institute, is **patient-centered care that removes the doctor-patient hierarchy.** It moves prenatal patients from the exam room into a conversation and support circle with other expecting mothers.
- Amy's research on Centering has shown an approximate **50% reduction in preterm births and an almost complete elimination of the racial disparity.**
- Evidence shows the model decreases neonatal intensive care unit admissions, improves doctor-patient relationships, and increases breastfeeding rates and family planning.
- Amy's work to scale the model across South Carolina has already generated **medical savings of over $7.2 million.**
- These outcomes have convinced South Carolina's **two largest medical insurers—Medicaid & Blue Cross Blue Shield—to come on board**, ensuring financial sustainability. **85% of pregnant women** in the state can now access CenteringPregnancy.

"The current model of healthcare is volume-based—the more ultrasounds I do, the more babies I deliver, the more I'm going to get paid," says Amy. The system is not geared to reimburse clinicians for value-creating work, like time spent on support functions. In order for Amy to convince medical practices to offer the program, therefore, she first had to convince insurers to pay for it.

This was always going to be a battle, and Amy was well out of her comfort zone: it was unheard-of for insurers to adopt a model such as this state-wide. "Nothing in my training prepared me for this," she says.

But the figures are persuasive: each preterm baby under five pounds racks up a bill of nearly $30,000 before the baby even goes home; each neonatal ICU admission costs nearly as much. If Amy could make a convincing argument based on indicative statistics about the number of such births CenteringPregnancy could prevent, there would be a clear business case for insurers to fund this form of preventative care.

> "CIRCLING IS A VERY HUMAN, ORGANIC AND NATURAL WAY OF SHARING INFORMATION. PEOPLE HAVE BEEN SITTING AROUND CAMPFIRES TOGETHER SINCE THE BEGINNING OF TIME."

South Carolina's biggest health insurers, Medicaid and Blue Cross Blue Shield, ultimately bought into the program, making it possible for 85% of all pregnant women in South Carolina to join. That policy win paved the way for the overall extraordinary influence Amy's venture is having on other states.

Although it's hardly a mainstream medical approach, "circling," Amy points out, is a very human, organic and natural way of sharing information. "People have been sitting around campfires together since the beginning of time. Group dynamics are powerful—the Aspen Global Leadership Network seminars themselves are founded on this principle. When you're lecturing to an audience, they're just getting one opinion, and it's relatively easy to discount just one person's opinion. But when you're in a group and 10 people are agreeing with a position, you're getting 10 opinions. As a physician, I can use the group to help reinforce information.

"Smoking is an example. I have talked to patients about smoking a million times, and it's hard when they walk out of the room for me to feel like they're really going to quit. But when you're in a group and they hear three or four people share strategies for how they quit, why they needed to quit, how glad they are that they quit, how much money they're saving, I've definitely thought: I bet she quits! It makes my job easier when I have the group behind me. It's just a totally different way of delivering healthcare."

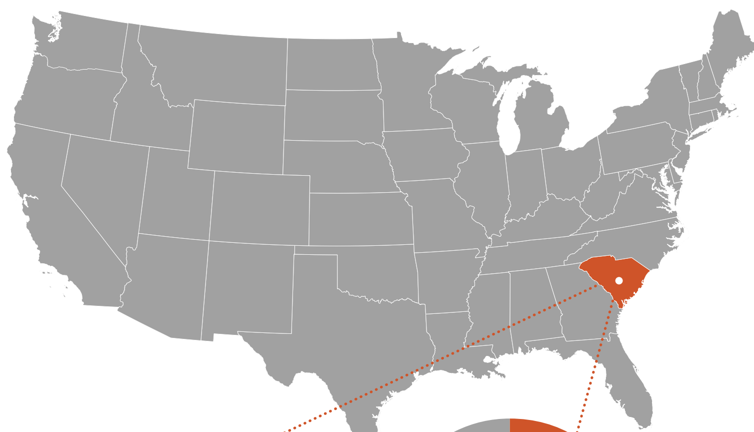
Amy reports exciting success: her CenteringPregnancy mothers have a preterm rate of under 9%, lower than the US average; and the racial disparity has been eliminated. Any number of babies who might otherwise have been born preterm and faced a lifetime of compromised health are being given a much better start.

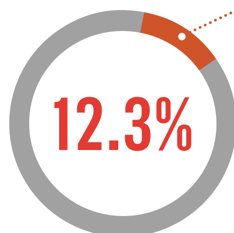
More than results, though, the direction of this work is built on the exciting hypothesis that personal connections are able to change the biologic foundations of pregnancy. The stress relief—provided by the simple fact of sharing the journey with women in similar positions—dramatically improves pregnancy outcomes. While this offers inspiring potential for prenatal care, it also opens up thinking about other fields in which a similar approach could produce positive health outcomes. Researchers are therefore also looking at what group care can offer to support patients with chronic conditions such as endometrial cancer and heart disease.

In pregnancy care, word has spread: inquiries have come from health facilities in 25 other states, and from as far afield as Mexico, and Amy's team is actively supporting others who seek to replicate South Carolina's success. As the research results come in, the application and validation of Centering methodology in disease environments is likely to result in a different way of thinking about clinical treatment.

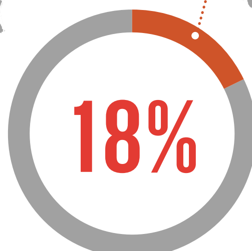
"Maybe the secret was hiding right in front of our eyes all along," says Amy. "It's not about me and my medical training, it's not about the newest surgery or drug. It's about creating a space for people to connect with each other."

THE MEDICAL CONTEXT





12.3% of women deliver preterm

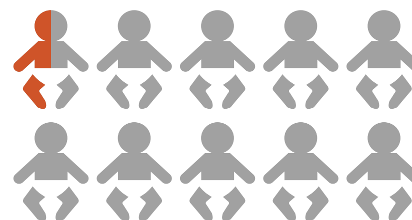


The preterm birth rate is higher for African-Americans—18%

In South Carolina, rates of preterm birth are **higher than in some poor developing countries** like Bangladesh and Sudan.

CenteringPregnancy has **brought the rate for all groups to below 9%**—an improvement even on the US average of around 10%.

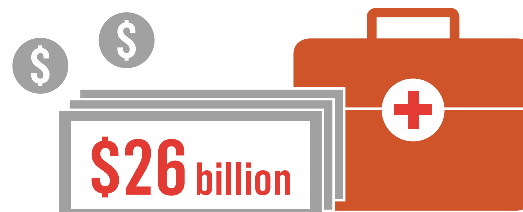
Over 500,000 US babies are born preterm every year



5% have severe lifetime consequences such as neurosensory and cognitive disabilities.

An average neonatal ICU admission costs upwards of $27,000

Preterm births in the US pose an immediate financial burden on healthcare resources, at **an estimated lifetime medical cost of $26 billion.**



IN HER OWN WORDS: WHAT AMY HAS LEARNED

Lean into the support of your network.
"I didn't have anybody in my immediate circle doing anything like this, so it felt like a big risk. But at my Aspen seminar on globalization, venture capitalists and professionals from around the world saw our start-up funding as a small risk. I was encouraged—it gave me permission to fail, which was really important."

Creating the space is often all that is needed.
"Some of the most powerful learnings emerge not from the information I have to share with my patients, but from the stories that the women in the circle share with each other. If I can give them that space to connect, they will give each other the information and the support that they need."

Gathering the evidence will make your case.
"Because the idea of group care is so new in traditional medicine, doing the research that can show the outcomes is critical. So far we've achieved a reduction of about 50% in preterm births, with significant immediate financial implications, and long-term social consequences. That's what has been persuasive."

The McNulty Prize is given in partnership with the Aspen Global Leadership Network.
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