Mark Masselli: This is conversation on the Healthcare, I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret I know your just back from a week in Copenhagen. Was Healthcare in the Denmark News why you are over there?

Margaret Flinter: Well people certainly were interested in talking about the National Healthcare System but the issues there a little bit different than the once we are facing in the US for instance it was quite a bit of discontent right now about limits on doctors making house-calls. That's right. With the budget cuts, **Danes** just can't call up and have their doctor stop by their house, 24x7 when they are sick anymore.

Mark Masselli: Yes, that is different. On future shows we are going to take a look at how healthcare is delivered around the world, but this week we are on our home turf and the focus of today's show is on a program called Centering Pregnancy. Margaret, just hearing the name Centering Pregnancy it sounds sort of cozy.

Margaret Flinter: Well that's certainly part of the appeal. It's a very different way of delivering prenatal care and it's more social and less isolating but the important thing is it seems to improve outcomes both for mom and for baby.

Mark Masselli: We will talk with the founder of the concept Sharon Schindler Rising who lives right here in Connecticut.

Margaret Flinter: But first we want to reflect back on our last show about the Retail Care Clinics. Last week we explored two different retail care models by talking with Sandra Ryan – Chief Nurse Practitioner Officer of Take Care Health Systems, and Dr. John Agwunobi – President of Wal-Mart's Health and Wellness Division.

Mark Masselli: We heard from listeners including Ed Sizensky of Maryland who said Retail Care Clinics was an excellent choice for discussion.

Margaret Flinter: Thanks Ed.

Mark Masselli: Ed told us he received basic healthcare from clinics inside targeted in Wal-Mart, because his doc wasn't open on nights or weekends. Ed writes we need to move away from the idea that people gets sick between Monday and Friday. Ed, we agree with you.

Margaret Flinter: And we also heard from Larry Dent a listener from Spencer West Virginia. He looks for Wal-Mart to expand the number of stores in the program because in his small town of 2200 people the local Wal-Mart hasn't yet developed such a clinic.

Margaret Flinter: Keep the comments coming by emailing us at conversations@chc1.com.

Margaret Flinter: Now let's get to recent healthcare headlines from our producer Lucy Nalpathanchil.

Lucy Nalpathanchil: I am Lucy Nalpathanchil with this week's headline news. As I reported last week the federal government has begun shipping doses of H1N1 Vaccine to states. The vaccine comes at a time when states have reported widespread flu cases according to the Center for Disease Control. The CDC reports just 2% of the doses have been shipped this week. Hospitals, community health centers, and public clinics, are distributing the vaccine to the public. CDC Director Thomas Frieden says there are priority groups who should receive the vaccine first.

Thomas Frieden: And initially for the FluMist the groups that are best to vaccinate for that are young healthy people like healthcare workers as well as people who care for infants as well as school children. When their shots come we want the five key priority groups to be vaccinated first, pregnant women, healthcare workers, individuals who have underlined health problems, people who care for infants and school children, and young adults up to the age of 24 years.

Lucy Nalpathanchil: Frieden says next week the injectable H1N1 vaccine will become available. In a conference call with reporters Health and Human Services Secretary Kathleen Sebelius said that Federal Government has paid for 250 million doses of the H1N1 Vaccine enough for every American who wants the vaccine. She also stressed it's up to individuals to decide if they want the vaccine saying the government's vaccine campaign is not mandatory. This week the Senate Finance Committee is expected to vote on a final healthcare reform bill. The vote comes after a long process of offering multiple amendments to Finance Chair Senator

Max Baucus' healthcare bill. After the finance committee votes out a final bill, senate majority leader Harry Reid will work to merge it with the senate health, education and labor committee bill. Its membership included a public option. The option did not survive in the finance committee. However in a phone town hall meeting with his constituent senator Reid says he wants to see the public option in the full senate's final bill.

Harry Reid: What the public option is about is an option, not a mandate it's an option to give people a choice. The reason for that is to keep insurance companies honest, to create a fair playing field. I favor the public option and before we finish with this I am, oh I feel very confident with public option. May not be the one the exact one I want but we will have a public option.

Lucy Nalpathanchil: Senator Reid also says congress must keep in mind that the final plan represents all of the nations' citizens

Harry Reid: One thing I want to say is that a conversation I had with President Obama, he said Harry when we finish this we have to make sure it's not just a program for poor people it's a program for the American people. That's something we always have to keep in mind.

Margaret Flinter: The house will also have to pass a final bill then both chambers must combine their work in conference committee. The president wants a final bill on his desk by year's end we will continue to follow what develops on Capitol Hill.

Lucy Nalpathanchil: This week conversation on healthcare explores Centering Pregnancy as an example of a healthcare innovation. Centering is a model of delivering quality healthcare in a group setting. Centering pregnancy is very different from traditional prenatal care where a woman goes to monthly checkups and often spends more time in a waiting room than with her doctor. In centering the provider meets regularly with a small group of women who would do around the same time. The informal meetings allow the provider to assess their pregnancies together and educate them about how to take care of their health or about the woman receives support from each other. Centering also extends to care after birth, and includes group pediatric care. At a centering pregnancy meeting inside a community health center Paddy **Varus** lays on an examining table. As a certified nurse midwife shows her how to measure her stomach to check her baby's growth.

Midwife: Okay, so Patricia you are thirty weeks okay, and we are going to measure and see this nice little belly. Okay you are measuring 30 centimeters which is just perfect and I feel there is this little head down here.

Paddy Varus: Oh I see, it is in a position.

Midwife: Oh yeah.

Lucy Nalpathanchil: After Varus has measured, she and five other women talk about their pregnancies and hear about the importance of getting a full shot. Varus says she is due in December and it's her second baby. She says centering has helped her feel empowered unlike the first time she was pregnant.

Paddy Varus: Here it is all about knowing everything, being aware of everything about your options and when it comes to delivery to your option with pain management and everything, so it's good to know and you go to the labor knowing everything but at the first time, it wasn't like that at all, so nobody told me nothing.

Lucy Nalpathanchil: Chasman and Berger sits near Varus smiling, it's her first pregnancy. She says her nurse midwife recommended centering and now she looks forward to meeting the women twice a month.

Patricia Varus: We are going through similar things and it's just, it puts your mind at ease. It's like you are not the only one you know.

Lucy Nalpathanchil: Studies by Yale University among others have found that women who participate in centering pregnancy were less likely to have preterm births than women who receive traditional care. It's that kind of success that prompted Dr. Stephen Patrick to bring centering to his clinic. Dr. Patrick is Director of the Residency Training Program in Obstetrics and Gynecology from Methodist Health System in Dallas. He says before centering 13% of the clinic's patients gave birth prematurely. Now the rate of preterm birth has dropped significantly.

Stephen Patrick: And now that we have about a year and half's worth of data in our own clinic we are actually seeing a dramatically low preterm birth rate of around 3% within that population.

Lucy Nalpathanchil: Dr. Patrick also points out that centering is good for the community. Many of the women he sees come from different ethnic

and socioeconomic backgrounds. But he says centering has shown the women that they have a lot in common, as they share stories about their pregnancies and their families. He adds the benefits also extend to healthcare providers because the nurse midwife or doctor spends much more time with patients in group care than with the patient one on one. Centering sessions can run two hours while a prenatal checkup with the doctor can run between 5 and 15 minutes. Family practice physician Dr. Janet Carpenter says spending more time with her patients was one of major reasons she brought centering to her private practice in Richmond, Virginia.

Janet Carpenter: My biggest frustration with the way the traditional care worked is that I just didn't feel like I spend enough time talking about the things that I think that are important in pregnancy and you could go through an entire pregnancy with even a 15-minute appointment with someone and never talk about breast feeding, never talk about birth control, never talk about nutrition, and you know you just talk about the essentials as is your baby moving and how are you feeling, and then it's time to move on.

Lucy Nalpathanchil: Although Dr. Carpenter says it's harder to incorporate centering in a small private practice because there isn't enough staff to train on centering and run the sessions while the other staff handles regular office calls. She believes additional private practice physicians will adopt centering; once more information comes out about the positive outcomes of group healthcare in Richmond, Dr. Carpenter is working to spread the word about centering, by applying for grants to study the effects of centering or lowering the rate of unintended pregnancies. And for those doctors and patients who have tried centering they all agree it's a model that's proven to be cost efficient while delivering quality care. Healthcare providers we spoke to pointed out that centering sessions and traditional one on one care are billed to insurance at the same price, but with centering the providers and the patients get more out of the group care experience. To hear more about centering pregnancy Mark and Margaret spoke to the founder of the centering model Sharon Schindler Rising.

Mark Masselli: Welcome to conversations on healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Today we are speaking with Sharon Schindler Rising Nurse, Midwife, Educator and Founder and Executive Director of The Centering Healthcare Institute. Sharon, thank you for joining us today.

Sharon Schindler Rising: Well thank you for having me.

Margaret Flinter: Sharon thanks again for being with us. Now, you developed the concept of centering pregnancy or delivering group healthcare to expect mothers out of your experience as a nurse midwife, can you tell us about the model and how it really works?

Sharon Schindler Rising: Well, yes. The, model, it's a group model of care and it really came out of my feelings as a provider that care or the questions that one woman had were the questions of another woman and that groups in general tend to work better than individual care. I have had lot of group experience. And so we had tested in prenatal care, we had really tested classes that we knew that women at the time of affiliation and women and couples really like to be together and that is also an interesting education or at least an opportunity for women to really test out their internal wisdom with perhaps a wisdom of professionals. And the only thing we really hadn't tested was the prenatal checkup and as I thought about that I thought well there is nothing terribly private about that. So what the centering model is, it's really bringing women or people because it's so much like a model as well out of exam rooms and intergroup for care. So it brings together the care and the education and the support or community building, all into one with almost all activities happening within the group space.

Mark Masselli: Sharon how do patients react to this model particularly those who have received the more traditional kind of office visit in the past?

Sharon Schindler Rising: Well I have some interesting data just collected from my private office where I was doing, I had been in the private office and I was just obstetrician and we really had, we had a good office, we ran a good office but I had a sub sample of about 60 couples who hade received care from us in our office before and now had gone through centering and I asked them about their experience how they would compare it to the individual care that they got with the previous pregnancy in our office, and 89% of the women and the dads actually as well said they like to better and the rest of the samples said they liked it at least as well. So I think that what we have found is that satisfaction of women with the model it's really just off the charts in terms of they really

do love it and I think it is the time that we are just meant to be in conversation with each other in general and certainly pregnancy is a time, one of the times in our lives when we really appreciate that opportunity.

Margaret Flinter: And Sharon you know healthcare reform is very much on our minds and everybody's minds these days and I want a few comments on how the centering model fits in with our across the board call for reforming healthcare in the United States today.

Sharon Schindler Rising: Well we really think we are on target for that Margaret we have looked at the Institute of Medicine has the aims for really improvement of healthcare, for redesign of healthcare and rules for redesign and we have actually I published a table on that really looking at how we feel that we are responding to the call for redesign of healthcare. It's just, it's a model of empowerment and community building. It's an effective model. Our outcomes, our health outcomes are improved, we have seen a really significant reduction in preterm birth from a randomized trial but also on other really fairly well constructed evaluation studies from different parts of the country. We have satisfaction data from providers, I mean providers write to me and say this is the one thing when I read it brings me joy. So I mean I want key providers active, we don't want to lose anybody at this time in healthcare reform and I looked at sort of the medical home concept or I prefer to call it the healthcare home concept and really think about how that whole model of care where patients have a home and it's developed throughout the lifecycle of how appropriate a group model would be within that whole initiative.

Mark Masselli: This is conversations on healthcare. We are speaking with Sharon Schindler Rising about the concept of centering pregnancy. Sharon, there seems to be a power in this idea of women coming together in building community, how else does this affect the women who are involved?

Sharon Schindler Rising: What we see is some really dramatic behavior change, that happens within the group. We really encourage the women o set goals for themselves, personal goals for their pregnancy and we have seen whole groups sort of shift from really drinking lots of soda, smoking, other behaviors perhaps not exercising to having really much better nutrition and decreasing or stopping smoking, really working on stress management and exercise. I mean this kind of, there is something, somewhat magical almost that can happen within the group as women say to each other I'll support you in that how can we work together.

Margaret Flinter: And you know Sharon physicians and midwives had been providing prenatal care for a long time and that was a powerful statement you made about this being a model of care that brings them joy. Where would a physician and nurse midwife go to be trained in the centering model if they want to try and implement in their practice.

Sharon Schindler Rising: Well we are working now, we have realized that there is a lot of system change involved in moving from a traditional model to a group model of care. So we are working in systems first of all to get them ready for group care and then following that we have a two-day training program or we really worked on facilitation. This is group so it's not class and it's kind of a big step for us as providers to really sit and listen and try not to answer questions but instead to really learn from the group and ascertain the group wisdom, which is really based a lot on cultural beliefs and values. So it's really a wonderful experience for us to do that and it's not all that easy to learn facilitation. So, we have two-day training workshops and really basically learning how to run groups and do facilitation and then we have level two facilitation workshops after people have had an opportunity to run groups. So the best way to really find out about what's happening is to get on our website which is www.centeringhealthcare.org and we have a lot of information there, we have upcoming workshops posted but they can also call us. We are here in the office are spending quite a bit of time on the phone really talking with individuals as well as administrators in larger systems about what it really means to move to a group model of care.

Mark Masselli: Sharon, do you have a phone number that people could call?

Sharon Schindler Rising: It's (203) 271-3632.

Mark Masselli: Thank you, and Sharon does centering pregnancy change the cost of delivering or receiving prenatal care?

Sharon Schindler Rising: Oh, it's a difficult question, Mark. The initial data that we have is that it's cost neutral but I really look at the long term cost effectiveness on the model. And as one medical director said to me for every one and half to two groups of women that you have, your data would say that you would save your system, one preterm birth. And we know that one preterm birth the average cost is $50,000 to $55,000 for the system so that if we are thinking of effectiveness of breast feeding, better really care for babies and children, and we do have centering

parenting which is continuously grouped on for the first year of life and beyond for well woman, well baby care that if we think of that the potential to really help women to achieve weight goals perhaps some prevention for diabetes, some depression counseling, screening, you know all of those things so in the broader look, is this going to save money I think absolutely for our larger systems and for the agencies themselves.

Margaret Flinter: And Sharon the centering model is practiced in private practices around the country and in community health centers around the country. Wouldn't you if have any particular thoughts about how you reach out to diverse communities particularly women who are low income, people of color, people for whom English may not be their primary language?

Sharon Schindler Rising: Well the majority of our sites are in federally qualified health centers or intercity clinics where women are coming and they are, there are all sorts of language challenges and cultural barriers to care and I think that the centering groups first of all they can be conducted in a specific language. We have all of material translated into Spanish and we have other translations as well so that again the culturally really appropriate care can be given and I think that the response that we are seeing from women we have by the way over 300 sites. We have sites in virtually every state and abroad, Canada and abroad but I think the, what the finding in these sites is that women are saying that they feel that they are getting respectful care. And I can't think of anything right now about would be more important.

Mark Masselli: And I think you are absolutely right, I know as you know Margaret and I run a community health center and I did talk to a group of woman after one of their sessions and I can't tell you about the power in the room and the networking that was happening where they really wanted to connect past these sessions which each other thinking about how to set up support groups in the like so it's really a very, very powerful means of delivering care. We have been speaking with Sharon Schindler Rising – Executive Director of Centering Pregnancy and Parenting Association. Thank you for joining us today.

Mark Masselli: Each week conversations highlight to bright idea about how to make wellness a part of our communities in everyday lives.

Margaret Flinter: This week we look to the workplace, Lucy.

Lucy Nalpathanchil: What business doesn't want to cut their cost for healthcare, reduce absenteeism and turnover, increase productivity and improve morale? Here is one sure strategy with a good return on investment, workplace support for breast feeding moms. Information on the health benefits of breast milk grows every year. It gives baby stronger immune systems and lower rates for infections, obesity, asthma and even lowers the risk of postpartum depression for new moms. But with 70% of mothers returning to work within six months that means there are a lot of women who have to figure out how to pump and store their milk if they want to follow the recommendations that babies are exclusively breastfed their first six months of life. But a new effort by a coalition called corporate voices for working families aims to improve those numbers by teaching businesses how to be more supportive of their employees who want to continue breastfeeding their babies. They have developed a toolkit on how to create a workplace lactation program with four simple steps: educate managers to be supportive as women plan their return to work, provide a private and secure place where new mothers can pump and store their milk, or just schedule us to allow a 20-minute break every three hours or so and then link moms to supportive services that can help them keep breastfeeding. The toolkit also points out the savings that a business can expect to see when new mothers breastfeed longer. They have tracked an improvement of 62% in healthcare cost compared to the babies of employees who were not breastfed. In all the discussion of reform and the cost of healthcare it's a good time to remember that nothing is as important as helping moms and new babies get after a healthy start in life and breastfeeding in the first year is at the top of the list. For more information about how to make your work place lactation-friendly go to www.womenshealth.gov. Now that's a bright idea.

Margaret Flinter: This is conversations on healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli peace and health.

Margaret Flinter: Conversations on healthcare broadcast from the Campus of Wesleyan University at WESU, streaming live with www.wesufm.org and brought to you by the Community Health Center.