There is evidence CenteringPregnancy, with its well-developed training and curriculum, can reduce preterm birth, the leading cause of infant mortality, particularly for African American women, who continue to experience deep disparities in birth outcomes.

Issue Brief:

How CenteringPregnancy Can Support Birth Equity

Independently prepared by
Health Management Associates for the
Centering Healthcare Institute

Executive Summary

- The United States faces a crisis of high maternal and infant mortality rates, with Black women at three to four times the risk as White women of death from pregnancy-related causes – risk that persists regardless of socio-economic differences. And Black infants have more than twice the rate of infant mortality as non-Hispanic White infants.
- The impact of racism and other inequities within the healthcare system and across the life course contributes to these disparities.
- Supporting birth equity requires holding the healthcare system accountable for addressing racism and social inequities.
- Birth equity advocates have identified and are expanding the reach of many different strategies and models of care to address racial and social inequities.
- There is evidence CenteringPregnancy, a specific model of group prenatal care with well-developed training and curriculum, can reduce preterm birth, the leading cause of infant mortality, particularly for Black women, who continue to experience deep disparities in birth outcomes.
- CenteringPregnancy has potential as one of a variety of strategies to support birth equity and is aligned with others; it can be layered with them to provide holistic, relationship-centered care that meets women's needs and supports health system accountability for birth equity.

The Need for Birth Equity[1]

The United States faces a crisis of high maternal and infant mortality rates, with Black women at three to four times the risk as White women of death from pregnancy-related causes – risk that persists regardless of socio-economic differences.[2,3,4] Maternal mortality rates have risen or been stable in the United States, while falling internationally.[5] Infants born to Black women are also at twice the risk of

[1] Joia Adele Crear-Perry, MD, FACOG, created the term birth equity and is the Founder and President of the National Birth Equity Collaborative.

[2] "Pregnancy-Related Deaths," Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Updated February 26, 2019. Accessed August 27, 2019. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm

[3] New York City Department of Health and Mental Hygiene (2016). Severe Maternal Morbidity in New York City, 2008–2012. New York, NY. https://www1.nyc.gov/assets/doh/downloads/pdf/data/maternal-morbidity-report-08-12.pdf

[4] Native American women also experience particularly high rates of maternal and infant mortality, though disparities are deepest for Black women. Racial disparities in birth outcomes are discussed in more detail at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm and https://www.cdc.gov/nchs/data/databriefs/db74.pdf, as well as by MacDorman et al (2016), referenced below.

[5] MacDorman MF, Declerq E, Cabral H, and Morton C. Is the United States Maternal Mortality Rate Increasing? Disentangling trends from measurement issues Short title: U.S. Maternal Mortality Trends. Obstet Gynecol. 2016;128(3):447–455.

death as White infants—13.3 per thousand infants compared to 5.6 per thousand.[6] The layered harms and stresses of structural racism across the life course, and the impact of racism within the health care system, including in the experience of prenatal care, contribute to these deep disparities.[7,8,9,10] Addressing this crisis requires creating conditions of birth equity, defined as the "assurance of the conditions of optimal births for all people with a willingness to address racial and social inequalities in a sustained effort."[11]

Leading coalitions calling for birth equity, such as the Black Mamas Matter Alliance and the National Birth Equity Collaborative, have developed and highlighted a variety of strategies to support birth equity, which address numerous aspects of the health care system and beyond. They center the voices, birth experiences, values, and expertise of women of color as critical to improving maternity care. The National Birth Equity Collaborative (NBEC), a leader in these efforts, "optimizes Black birth outcomes through training, research, community-centered collaboration, and advocacy. NBEC uplifts Black women-led organizations, guiding clinicians and researchers to center women, their families, and their stories."[12] The growing recognition of birth equity as a priority for maternal and infant health efforts is also reflected in the recent March of Dimes Prematurity Collaborative statement that embraces birth equity and calls for:

- Expanding the scope of research on social determinants of health as fundamental drivers for population maternal and infant health
- Engaging in health system reform, including re-educating providers on implicit racial bias, to better serve highest-risk populations
- Empowering communities through inclusion, education, social activism and advocacy

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[6]MacDorman MF, Mathews TJ. Understanding racial and ethnic disparities in U.S. infant mortality rates. NCHS data brief, no 74. Hyattsville, MD: National Center for Health Statistics, 2011. https://www.cdc.gov/nchs/data/databriefs/db74.pdf

[7] Dominguez, T. P., Dunkel-Schetter, C., Glynn, L. M., Hobel, C., & Sandman, C. A. (2008). Racial differences in birth outcomes: the role of general, pregnancy, and racism stress. Health psychology: official journal of the Division of Health Psychology, American Psychological Association, 27(2), 194–203. doi:10.1037/0278-6133.27.2.194

[8]Alhusen, J. L., Bower, K. M., Epstein, E., & Sharps, P. (2016). Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. Journal of midwifery & women's health, 61(6), 707–720. doi:10.1111/jmwh.12490

[9] Rich-Edwards, Janet W. et al. Psychosocial stress and neuroendocrine mechanisms in preterm delivery

American Journal of Obstetrics & Gynecology, Volume 192, Issue 5, S30 - S35

[10] "Lost Mothers: Nothing Protects Black Women from Dying in Pregnancy and Childbirth," Nina Martin, ProPublica, and Renee Montagne, NPR News. December 7, 2017. https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth

[11] "Birth Equity Solutions," National Birth Equity Collaborative. Accessed August 27, 2019. https://birthequity.org/about/birth-equity-solutions/

[12] "Mothers' Voices Driving Birth Equity," National Birth Equity Collaborative. Accessed August 27, 2019. https://birthequity.org/what-we-do/mothers-voices-driving-birth-equity/

- Advancing work to change social and economic conditions (poverty, employment, low wages, housing, education, etc.) underlying health inequities[13]

In recent years, hospitals and health systems have increasingly focused on implementing safety protocols to treat pregnancy and birth complications, but these have been insufficient to close gaps in maternal mortality between women of color and White women, disparities which are particularly severe for Black women and Native American or Alaska Native women.[14,15] The stress caused by the experience of racism over the life course, as well as by discrimination during perinatal care, drives high rates of adverse birth outcomes across all income groups and even in the absence of medical or social risk factors.[16,17] Recent research found that among women in the United States with lower socioeconomic status, 27% of women of color reported being mistreated as part of their birth experience, compared to 19% of White women. "Our findings suggest that mistreatment is experienced more frequently by women of [color], when birth occurs in hospitals, and among those with social, economic or health challenges. Mistreatment is exacerbated by unexpected obstetric interventions, and by patient-provider disagreements," the authors wrote.[18] Disparities in outcomes also persist across socioeconomic lines.[19] In order to realize birth equity, "Promoting a culture shift from blaming Black women for risk factors and 'poor choices' that lead to poor outcomes to developing interventions to tackle racism and systems that do not serve Black women well" is necessary, said Joia Adele Crear-Perry, MD, FACOG, Founder and President of the National Birth Equity Collaborative.

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[13] Consensus Statement: Birth Equity for Moms and Babies—Advancing social determinants pathways for research, policy and practice. March of Dimes, October 2018. https://www.marchofdimes.org/materials/Collaborative-HE-Workgroup-Consensus-Statement.pdf.

[14] Main EK, McCain CL, Morton, CH, Holtby S, and Lawton ES. Pregnancy-Related Mortality in California Causes, Characteristics, and Improvement Opportunities. Obstet Gynecol. 2015;125:938–947

[15] "Pregnancy Mortality Surveillance System," Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Updated June 4, 2019. Accessed August 27, 2019. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm

[16] Harrell, C. J., Burford, T. I., Cage, B. N., Nelson, T. M., Shearon, S., Thompson, A., & Green, S. (2011). Multiple Pathways Linking Racism to Health Outcomes. Du Bois review: social science research on race, 8(1), 143–157. doi:10.1017/S1742058X11000178

[17] FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. BMC Med Ethics. 2017;18(1):19. Published 2017 Mar 1. doi:10.1186/s12910-017-0179-8

[18] Vedam S, Stoll K, Khemet Taiwo T, Rubashkin N, Cheyney M, Strauss N, McLemore M, Cadena M, Nethery E, Rushton E, Schummers L, Declercq E, and the GVtM-US Steering Council. The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. Reproductive Health (2019) 16:77 https://doi.org/10.1186/s12978-019-0729-2

[19] Petersen EE, Davis NL, Goodman D, et al. Racial/Ethnic Disparities in Pregnancy-Related Deaths — United States, 2007–2016. MMWR Morb Mortal Wkly Rep 2019;68:762–765. DOI: http://dx.doi.org/10.15585/mmwr.mm6835a3

Strategies to Address Birth Equity

The health care system can and must be accountable for addressing racism and other drivers of inequity, as part of broader efforts to do so. Expansion of existing and new care models, changes to the maternity care workforce, training to address racial bias and equity across the health system and beyond, and data collection that illuminates disparities all play roles in supporting birth equity.

Delivery System

A variety of care models and workforce strategies can help to address racial and social inequities and create opportunities to empower patients and meet their needs. Health plans and states can support access to doulas and to midwifery care by reimbursing for these services and helping to raise awareness of these models' potential to provide support during prenatal care, at birth, and in the postpartum period. Several states have begun taking steps to cover doula care.[20] Birth centers, which offer a midwifery model that allows more time for appointments with a more holistic and less medicalized approach to pregnancy, are similarly advocating for higher reimbursement and awareness of their services. There is evidence that birth center care can help reduce racial disparities in birth outcomes.[21] Longstanding models of care developed by women of color to support communities of color can be expanded. For example, the JJWay® is a community-based midwifery model that uses a trauma-informed approach to providing wrap-around care.[22] Community-based organizations across the country offer Black women access to Black doulas, midwives, and other providers to support culturally sensitive care and reduce stress from discrimination in the course of prenatal care.

Training to reduce implicit and explicit bias from providers and other participants in the healthcare system is another element of many organizations' pursuit of birth equity, often in combination with other strategies. This can lead to behavior change that improves the quality of care, as well as to greater understanding of the role of power and privilege in perception and care delivery. Training on bias and equity should influence leadership and hiring decisions throughout the health care system, helping to shape the work force and institutions in ways that reduce discrimination and support equity in care delivery. Bernadette Kerrigan, Executive Director of First Year Cleveland, said "If you're going to be part of the solution, all systems need to recognize and get tools to understand racism, and use interventions that work to check biases at the door, or you should not be serving Black parents and expectant parents." First Year Cleveland has been conducting racial bias testing, training and human resources transformation as part of its efforts to address structural racism within the health care system.

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[20] "To Reduce Fatal Pregnancies, Some States Look to Doulas," Mattie Quinn, *Governing*, December 21, 2018. https://www.governing.com/topics/health-human-services/gov-doula-medicaid-new-york-2019-pregnant.html

[21] "National Evidence Confirms Birth Centers Deliver Improved Health Outcomes at Lower Cost," Diane W. Shannon, MD, MPH, for the American Association of Birth Centers, January 8, 2019. https://www.birthcenters.org/page/strong-start-national-report

[22] Commonsense Childbirth, *The JJ WAY: Community-based Maternity Center Final Evaluation Report 2017*. https://secureservercdn.net/198.71.233.109/f3b.e30.myftpupload.com/wp-content/uploads/2019/07/The-JJ-Way%C2%AE-Community-based-Maternity-Center-Evaluation-Report-2017-1.pdf

Data Collection and Analysis

Robust data collection that disaggregates data to enable providers and community partners to identify disparities and needs is foundational to promote equity. "You can't address equity issues if you don't know what differences are in your patient population," said Jaye Clement, MPH, MPP, Director of Community Health Programs & Strategies, Community Health, Equity & Wellness at Henry Ford Health System. "It's one thing to say, 'these are the standards of care and we expect providers to follow them--do them and you'll have great outcomes.' Drill down into the data to see differences in populations and follow what's going on to see if you're achieving equity or not. For example, looking at the state's infant mortality rate overall you may think you're fine – but seeing disparities in Detroit or Flint enables you to identify equity issues." Of note, the National Birth Equity Collaborative is developing a participatory patient-reported experience metric of mistreatment and discrimination in childbirth, which will enable direct measurement of these experiences and the impact of efforts to improve care.

Data collection can also tie in to greater inclusion of patients in improving care delivery. "We can't advance racial equity without disaggregating data by race," said Kelly McKay-Gist of Equity in Infant and Maternal Vitality Initiatives at the St. Louis Integrated Health Network. "We want to make sure we have a clear vision of who patients are, and we bring patients to the table to actively collaborate on redesigning care delivery. We need to reimagine what care can look like from a patient perspective, how providers can give up power, listen, and act on that perspective. We can't meet needs otherwise. This process must not tokenize community members – they must have power to make decisions and implement their decisions that shape their care and the system." Dr. Crear-Perry also highlighted that the status quo of traditional maternity care is not always evidence-based, yet efforts to change it are often required to prove their effectiveness in order to gain institutional support, within research and policy frameworks that have often excluded communities of color. She noted, "There is an element of who controls the aspect of being evidence-based. If small community organizations cannot prove they meet 'evidence-based standards,' success is not supported, whereas much of traditional medical care is not evidence-based either." Research approaches that can more effectively capture what works for different communities are an important ingredient of pursuing birth equity.

Funding and Sustainability

Strategies and care models that support birth equity need sufficient, sustainable funding to be successful. This includes reimbursement for community-based providers and other community-based organizations whose work addresses inequities, for midwifery care models, doulas, and group care models such as CenteringPregnancy. Both private and public health care payers can contribute to supporting these models—and states' willingness to reimburse for them is growing, as evidenced by states beginning to reimburse for doula services and group prenatal care.

CenteringPregnancy as a Strategy to Support Birth Equity

CenteringPregnancy has a potential role as one of the models supporting birth equity, as a free-standing or complementary group prenatal care model that is relationship-centered, holistic in its attention to non-medical aspects of health and wellbeing, provides time and opportunity for empowering group discussion, and creates a supportive environment that fosters trust. CenteringPregnancy is a care model in which facilitators support a cohort of eight to ten women of similar gestational age through a curriculum of ten 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding, and infant care. "In order to achieve birth equity, we have to listen to what the community wants, and that is the core of what CenteringPregnancy offers," Dr. Crear-Perry said of the model. Major components of the model align with needed priorities in pursuing birth equity, including:

- **Relationship-centered care:** CenteringPregnancy represents a fundamental shift from the traditionally hierarchical, top-down model of American medicine to facilitated group discussion, peer education, and support. The interactive group discussion provides time and opportunity for group participants and facilitators to develop mutual trust and strong relationships. The format and content of CenteringPregnancy align with the framework of relationship-centered care, which involves four principles: (1) that relationships in health care ought to include the personhood of the participants, (2) that affect and emotion are important components of these relationships, (3) that all health care relationships occur in the context of reciprocal influence, and (4) that the formation and maintenance of genuine relationships in health care is morally valuable.[23] Extensive evidence demonstrates that the development of relationship-centered care improves not only patient satisfaction but also health outcomes, and that it can lower costs.[24] Not only does CenteringPregnancy enhance the relationship between participants and prenatal care providers, but the model fosters a group support dynamic. Women learn from each other and also hear from others about questions that may not have come up for them yet. Many groups form strong social connections that last beyond the birth.
- **Time to identify and address needs in a holistic way:** CenteringPregnancy sessions offer far more time for discussion than the typical brief individual prenatal care visit—time that is necessary to explore and share information about the wide range of medical and non-medical needs and topics that are relevant to pregnancy, birth, and the postpartum period. The prolonged time also allows the facilitators to get to know participants. In a serial individual prenatal care model, a clinician may only spend a total of two to three hours with a woman throughout her entire pregnancy, whereas in the CenteringPregnancy model, they spend at least 15 hours with the group. In addition, Bernadette Kerrigan pointed out, there is a "group dynamic of people reinforcing what they're learning with each other outside the health care system, sharing information when they see each other in the community, on the playground, or

[23] M.C. Beach, T. Inui, et al, "Relationship-centered Care, A Constructive Reframing," J Gen Intern Med 21 (2006): S3–8.

[24] M. Kirkegaard and J. Ring in "The Case for Relationship-Centered Care and How to Achieve It," Health Management Associates, February 3, 2017. https://www.healthmanagement.com/wp-content/uploads/The-Case-for-RCC-final-2-9-2017.pdf

at the library. Women learn through each other and don't have to wait for the next doctor appointment."

- **Enhanced community competency:** The prolonged time spent in interactive discussions allows the CenteringPregnancy facilitators to learn more about the communities in which participants live and raise their children. This promotes greater understanding of cultural norms and also helps the health system better understand the needs of different communities.
- **Empowerment and respect:** The facilitative model is empowering, honors participants' experience, and supports group members to learn from and support one another. These group dynamics are central to the model's effectiveness: the more CenteringPregnancy facilitators create a participatory atmosphere in the group, the more significant reductions in preterm birth and need for intensive care utilization are.[25] As Amy Crockett, MD, who led the South Carolina CenteringPregnancy Expansion Project, put it, "CenteringPregnancy really empowers women. It creates a level playing field. It leads to a higher level of trust between women and providers. Women are more likely to speak up when there is an issue and not say, 'I'll just wait.'"
- **Enabling collaborative, team-based care:** CenteringPregnancy supports a team-based approach that can integrate nurse practitioner, certified nurse-midwife, physician, or community health worker facilitators, involve behavioral health techniques or providers, and make connections to community-based resources and providers. Rather than a referral during an individual appointment, CenteringPregnancy groups can host guests from local organizations and allow time for discussion and connection to a wide variety of resources (e.g., related to nutrition, housing, intimate partner violence, or behavioral health) in the group setting.

The Centering Healthcare Institute developed the CenteringPregnancy model and supports practices around the country to implement and sustain it through training, implementation support, and ongoing technical assistance.

[25] Novick et al, Am J Obstet Gynecol. 2013 August; 209(2): 112.e1–112.e6. doi:10.1016/j.ajog.2013.03.026

Benefits of CenteringPregnancy

Research suggests that CenteringPregnancy holds promise especially for supporting improved birth outcomes for Black women and their babies, particularly reducing the risk of preterm birth. One study found that CenteringPregnancy reduced very early preterm delivery (before 32 weeks) to 1.3% compared to 3.1% for individual care, and preterm delivery to 7.9% compared to 12.1% for individual care. The racial disparity in preterm birth for Black women relative to White and Hispanic women was virtually eliminated in this study.[26] In another, Black women were substantially less likely to have a preterm birth in group prenatal care as compared to individual care – the rate fell from 15.8% to 10%. CenteringPregnancy participants were less likely to have inadequate prenatal care than women who received individual care, felt more prepared to give birth and more knowledgeable about perinatal topics, had higher satisfaction with their care, and were more likely to breastfeed (66.5% vs. 54.6%).[27]

From a provider and health system perspective, CenteringPregnancy is an opportunity for health care providers and the health care system to learn from and with the populations they serve. The community-building and problem-solving capacity of CenteringPregnancy has the power to go beyond the confines of the group. Participants can take the discussion and ideas back to their communities, then return to the group, creating an interplay of ideas, resources, and opportunities for facilitators and the system more broadly to learn.

WIN Network: CenteringPregnancy with Community Health Workers as Co-facilitators, and System-Wide Racial Equity Training

Women-Inspired Neighborhood (WIN) Network: Detroit, a program originally created by the Detroit Regional Infant Mortality Reduction Task Force and now housed within Henry Ford Health System, developed a CenteringPregnancy model that incorporates community health workers (CHWs) as co-facilitators of CenteringPregnancy groups. CHWs also conduct home visits with expectant parents, continuing through the baby's first birthday. CHWs are able to meet families where they are and infuse connection to community resources throughout the CenteringPregnancy model. As part of the first session, participants (who often bring a partner or other family member) develop a vision board for their birth experience and life more broadly, which the CHW references throughout care to support participants more effectively. This CenteringPregnancy model is most focused on enrolling Black women because of the disparities they experience in infant mortality rates, but the group is open to whoever wants to join.

The Task Force also integrated racial bias and equity training across the community for 500 health care providers and staff over 2013 to 2015. The curriculum specifically focused on maternity care issues, with built in case studies of how workflows and system-level issues can harm vulnerable women. The goal of the trainings, which the organization is in the process of expanding to a broader audience, was to provide concrete strategies for providers to pursue equity in their daily practice—and ultimately to orient health care organizations to address systemic bias through their hiring and leadership decisions.

"We really are dedicated to listening to the community and amplifying their voice in our work. It's such an asset when you have a well-informed product because you're meeting the needs, intentions, and desires of people you're serving and community partners. And it is empowering for providers to amplify voices of the community, reflect their values, and influence other provider types to improve their practice to be more community-driven." – Jaye Clement, Henry Ford Health System

[26] Picklesimer AH, Billings D, Hale N, Blackhurst D, and Covington-Kolb S. (2012). The effect of CenteringPregnancy group prenatal care on preterm birth in a low-income population. *Obstet Gynecol*, 206(5): 415.

[27] Ickovics JR, Kershaw TS, Westdahl C, Magriples U, Massey Z, Reynolds H, and Rising SS. (2007). Group Prenatal Care and Perinatal Outcomes. *Obstet Gynecol*, 110(2): 330-339.

"I believe in the secret sauce with CenteringPregnancy – putting humanity back into the patient-provider dyad is essential to restoring dignity to the birthing process, which is especially critical in a time when pregnant people, particularly women of color, are subject to escalating discrimination, from the federal to local level, to personal interaction with the health care system," Kelly Davis, Director of New York City's Birth Equity Initiative, said. She emphasized the need to continue expanding the CenteringPregnancy model, with resources that are linguistically competent and culturally humble, to better serve Black people, undocumented families, gender non-confirming and trans birthing people, Latinx communities, and South Asian communities. The model has potential to support many more women and birthing people if it is made more accessible. With respect to maternity care, in addition to an expanding CenteringPregnancy program, New York City has extensive ongoing efforts focused on hospital quality improvement around maternity care, as well as to conduct racial bias training, and state policymakers have taken steps to make doula care more accessible.[28]

Addressing Challenges to CenteringPregnancy

CenteringPregnancy represents a shift from the individual, top-down model of traditional prenatal care to a group-based, facilitated peer-learning model, and it requires significant shifts in administrative planning, scheduling, and billing, which can be accommodated with thoughtful planning and institutional support of the model. Financial sustainability is often a challenge for practices providing CenteringPregnancy care after the typical grant-funded start-up period, though CenteringPregnancy sites and their partners are increasingly working with states and health plans to secure ongoing payment. For example, New Jersey recently enacted a law that will provide enhanced reimbursement for CenteringPregnancy in Medicaid, as part of broader efforts to make the care model more accessible. Some women who wish to participate in CenteringPregnancy may be prevented by lack of flexibility in their schedule, inability to arrange reliable transportation, language barriers, and lack of childcare during the scheduled CenteringPregnancy sessions. Smaller providers, especially those in rural

St. Louis Integrated Health Network and Partners: Integrating Trauma-Informed Behavioral Health Care and Racial Equity Training into CenteringPregnancy and Beyond

A trans-disciplinary collective of CenteringPregnancy sites active in St. Louis enhanced the CenteringPregnancy curriculum by adding a trauma-informed approach and behavioral health tools such as motivational interviewing, brief cognitive behavioral therapy, or mindful stress reduction, in an effort to better address toxic stress as part of the group model. Facilitators also make referrals to behavioral health providers when appropriate. Through a pilot program, providers are conducting repeated screening for anxiety, depression, and stress over the course of prenatal care and postpartum. CenteringPregnancy providers also participated in racial equity training and follow-up coaching to dismantle systemic practices that reinforce racism within health care. This is part of a broader effort to develop a framework to integrate trauma informed care and racial equity, both during prenatal care and more broadly to support women and families across the life course. Integrating behavioral health with medical services and integrating trauma informed care with racial equity creates shared accountability within healthcare to address the impact of racism on health and focus on whole person wellness.

[28] Lost Mothers: New York City Launches Initiative to Eliminate Racial Disparities in Maternal Death, Annie Waldman, ProPublica, July 30, 2018. https://www.propublica.org/article/new-york-city-launches-initiative-to-eliminate-racial-disparities-in-maternal-death

areas, may not have enough women at the same gestational age to develop a CenteringPregnancy group.

Further Opportunities for CenteringPregnancy to Support Birth Equity

The Centering Healthcare Institute (CHI) is undertaking a variety of internal and external efforts to address the effects of structural racism, promote equity, and ensure that the CenteringPregnancy model fulfills its potential to support better birth outcomes.[29] "Underlying all this is a strong belief that structurally, CenteringPregnancy has a unique opportunity to make change. We have a commitment and responsibility to do so," said Angie Truesdale, Chief Executive Officer. Over the next year, CHI will be integrating implicit bias training into all CenteringPregnancy facilitator training. Patient and provider materials are in the process of being digitized for translation into additional languages, to support increased linguistic competence of the materials, as a key step in making the model accessible to more communities.

CHI also recognizes that internal equity work is also critically important and is building on ongoing efforts by implementing mandatory implicit bias training for all staff. This training is a result of learning alongside First Year Cleveland and is based on its model of racial bias testing, training and human resources transformation. CHI is also undertaking a design process with an organization that builds capacity for organizational change to support social justice and racial equity, to further identify tools and processes for ongoing work to support equity.

Conclusion

CenteringPregnancy offers the flexibility, time, and support structure to be a foundation for a variety of interventions and approaches that support birth equity. There is evidence that it can reduce preterm birth particularly for Black women, who continue to experience deep disparities in birth outcomes. CenteringPregnancy is a promising strategy in promoting birth equity and is complementary to other strategies that can be employed as part of broader efforts to reduce health disparities and hold the health system accountable for addressing racism and other systemic inequities.

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- **Amy Crockett**, MD, MSPH, Clinical Associate Professor, Department of Obstetrics and Gynecology, Clemson University School of Health Research
- **Kelly Davis**, MPA, Director, New York City Birth Equity Initiative, New York City Department of Health and Mental Hygiene

[29] The Centering Healthcare Institute's commitment to equity, diversity, and inclusion is described in greater detail at: https://www.centeringhealthcare.org/equity-diversity-and-inclusion

- **Bernadette Kerrigan**, MSSA, LISW, SPHR, Executive Director, First Year Cleveland, Case Western Reserve University School of Medicine
- **Kelly McKay-Gist**, MSW, LMSW, Program Coordinator, Equity in Infant and Maternal Vitality Initiatives, St. Louis Integrated Health Network

Birth Equity Organizations & Related Resources

To learn more about and support birth equity efforts across the country:

- **National Birth Equity Collaborative**
  https://birthequity.org/
- **Black Mamas Matter Alliance**
  https://blackmamasmatter.org/
- **March of Dimes Birth Equity for Moms and Babies Consensus Statement**
  https://www.marchofdimes.org/professionals/Birth-Equity-for-Moms-and-Babies-Consensus-Statement.aspx