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Megan: Hello everyone and welcome to the Centering Pregnancy Centering Parenting Innovative Models for Prenatal, Well-Woman, and Well-Baby Care webinar. I'm Megan Hiltner and I'm with the Healthy Start Epic Center. I'll be moderating today's webinar. We have approximately 60 minutes set aside. The webinar is being recorded, and the recording along with the transcript and slides will be posted to the Epic Center website following this webinar.

Before I introduce your great speakers for today I have a couple of housekeeping announcements. We really want your participation during the webinar. So if at any point you have questions or comments please chat them in at the bottom left corner of your screen. We will be taking questions just via the chat, but we will be taking them at the end of the speakers' remarks. If we don't get to all of your questions by the end of the webinar, we will be including them in a frequently asked questions document that we'll post with the webinar materials on the Epic Center website.

One other housekeeping point is that we'll be showing a video today. So please make sure your computer speakers are un-muted. You'll be asked to complete an evaluation survey at the end of the webinar and we really do want your feedback so please take a moment to complete that evaluation. Now let me introduce your dynamic speakers for today. John Crane and Tanya Monroe are both regional directors at the Centering Healthcare Institute. They both oversee centering activities across the country, and they both interface with centering practice cites and centering consortia. They're both actively involved in both policy and advocacy work and it is my great pleasure to turn it over now to them to begin the presentation. John and Tanya, take it away.

John: Okay, thanks Jodie and thanks Megan. Thank you everyone for joining us today for this webinar. Today we'll be looking at the centering pregnancy and and centering parenting models of care. Before we get there we're just gonna let you know who you're speaking with. There we go. So there a photo of myself and there's Tanya. You'll hear from Tanya shortly but we're both sitting here side-by-side. The objectives for today's webinar are to learn about the centering pregnancy and centering parenting group care models. We're going to examine the evidence supporting centering. We're gonna see how these models support Healthy Start's five approaches, and we're gonna look at ways that Healthy Start grantees can integrate centering into their programs.

Tanya: So we thought it would make sense to start at the very beginning and say, "Centering, what is it? What is this centering model that everyone's talking about?" Centering is a group healthcare model that's changing how families and healthcare providers experience care. It combines the care elements of a visit with learning and community building. Centering group care replaces traditional individual visits which is important to remember. In centering, groups of patients meet together for sessions that are facilitated by a care team of two people anchored by the healthcare provider who is joined by a co-facilitator which could be another staff member.

Through this facilitated session patients actively participate in their own care and are able to take ownership of their health information. Group sessions usually last an hour and a half to two hours and they meet regularly over a set period of time. What this means is patients have lots more time with their provider and also get to know and enjoy being with others with similar health concerns in groups. It also means there is no wait time. Groups start and end on time and when women begin care in centering they can know their schedule for all of their sessions when they enroll.

The centering model is defined by 13 essential elements. We won't go into too great of detail on the essential elements during this webinar, they are on our website if you'd like to research them a little more in depth. But these really play an important role in defining what centering is and it's what kind of sets us apart from other group care models. Essential element number one, I'll just call out some of the important ones, is that your health assessment, and during prenatal care this would be tummy check, occurs within the group space.

It's not in an exam room, it's not separate from where the group session will be taking place, and this really helps to normalize care, build patient self-efficacy, and promotes group interaction with community support from the very beginning of care. It reduces barriers between the provider and the patient and has many other benefits that are kind of hard to, hard to describe until you've actually experienced them. Participants are involved in their own care, they're taking their own vitals, they're either using a shadow chart or directly contributing information to their health record.

The group is facilitated, it's not didactic, it's not a classroom approach to care, and there are other themes of emphasis throughout the elements that you'll see. Another is that the centering groups happen in an open circle. There is an emphasis more on process than content and we'll talk a little bit more about that later on. There's also an emphasis on stability, that the provider and the co-facilitator are the same throughout all of the group sessions and that the members are relatively stable throughout the sessions as well. We understand folks may come in late to care or miss an appointment here and there. Also group size is key. You know, in order for group care to work you need a cohort that is big enough to have good dynamics and good energy. So we recommend certain ranges for both centering pregnancy and centering parenting.

Another element that is something we think is unique about centering is that support people are encouraged to participate. So if you're a pregnant mom you are bringing your partner or a family member, mom, sibling, with you to your healthcare appointment. I will take a moment to call out rather the 13th essential element which is their ongoing evaluation of outcomes. If any of you are currently at a centering practice site you'll know that we are evaluating the process, the outcomes, the experience every step of the way and always looking for new ways to learn from our evaluation and improve our process and our model. Now to tell you a little more about each of the two care models.

The first is centering pregnancy and this is prenatal care. This is for groups of between 8 and 12 women come together for their prenatal care over 10 sessions starting usually between 14 and 17 weeks into their pregnancies. These sessions follow the ACOG guidelines for prenatal care. You do have a curriculum, you have a patient notebook for each month that is very interactive and will help her record progress through her pregnancy and cover all of the content, as well as the facilitator guide for the provider and facilitator team that are leading the group. Yeah. That's the general gist of centering pregnancy.

Centering parenting is the continuation model which is well-mom well-baby care and one thing that I always love to remember to tell folks is that centering parenting was created as a reaction to moms from centering pregnancy who refused to stop coming for care together after their babies were born. This was developed out of a need of the moms to still come together for care with their

newborns through the first year of life. It does combine well-mom and well-baby care so just imagine, worked very nicely in family practice and can also be divided between an OB and Peds practice with some careful attention.

There are between five and eight dyads for groups so moms and their babies, dads or partners of course are welcome. Right now it's designed to be nine visits over the first year following Bright Future's guidelines and throughout the sessions having a focus on the three components of health, safety, and development for both mom and baby. Later on this year we're actually going to be looking at the curriculum for centering parenting and expanding that through the second year of life to better fit the visits as recommended by American Academy of Pediatrics.

John: Thanks, Tanya. So now we're gonna just take a quick look at a three-minute video and this video is something that we developed to help with our practice sites. Typically when a champion comes to us, we call them a centering champion, the person who is driving the centering implementation at a practice site. This was designed to help them communicate the message about what centering is to the staff at large so that everybody could get on board with the centering implementation. So, now we're gonna show you that video.

[Video Starts 0:10:20]

John: Okay. So, that was the overview of centering. Centering pregnancy in particular actually. Now what I'd like to do is just talk a little bit about some of the evidence base for centering. The evidence base really is primarily around centering pregnancy just so you're aware that our centering practice sites, our pregnancy sites outnumber our parenting sites by about 10 to one. But we are doing everything we can to promote the parenting model as much as possible.

So looking at some of the research behind centering, there's a 2007, a team from Yale published a multi-site randomized control study of 1,047 women, and they found a 33% reduction in pre-term births in centering patients compared to those receiving only individualized prenatal care. In that same study the reduction among African Americans was even higher at 41%. In 2012, a retrospective cohort study led by researchers at the Greenville Health System in South Carolina compared 316 women in centering to 3,767 women in traditional care and found a 38%

reduction in pre-term birth in centering patients compared to those receiving only individualized care.

Another study in 2009 of 379 women in rural Kentucky reported average pre-term birth rate of 6.6% among women in centering versus 13.7% as a regional average over the preceding years. These are just a few examples of the evidence supporting centering. If you go to our website there's a bibliography available there that lists many more studies and there's currently ongoing research in several place around the country looking at all sorts of different aspects about centering. They are really all showing the same sort of impressive levels of reductions of pre-term birth and low birth weight and breastfeeding initiation among other things, other quality measures.

Tanya: Great, and that leads us to talk about what is Centering Healthcare Institute doing internally to also keep track of our outcomes and the impact we're having on families' lives across the country. What we're doing is all of our practice sites have a data system that we designed called Centering Counts. It serves several purposes. It helps to measure fidelity to the model, it helps the practice set and follow their progress towards scale goals, and it also helps to measure outcomes. Like patient satisfaction, pre-term births, breastfeeding, low birth weight, and other indicators.

We also have sites that are doing data collection above and beyond what's in Centering Counts but we wanted to make sure that everyone was starting with the same tool and the same baseline data so that we could begin to aggregate the impact we're having across the country. Right now it is designed to be used site-by-site. It's based in Microsoft Excel with several survey tools that can be administered, you know, using paper. What we're working on currently is we received a grant to build out Centering Counts from the Excel-based tool to an online tool that will be a lot more acceptable and easy to use. So we'll be continuing development of that through 2015 and rolling it out next year.

What's even more exciting than knowing that Centering Counts exists is what we're seeing in the data that sites are reporting to us. We are still getting some data trickling in from last year but this is, I think, a really good overview of what we saw in 2014. We had just over 110 sites, these are all sites that we consider approved. They've been evaluated for model fidelity. So these are approved

centering sites reporting their data through Centering Counts and these are the outcomes we're seeing. This is just astonishing to us especially knowing the mix of practice settings and mix of women that are in centering across the country. Many, many of these would be considered high-risk due to socioeconomic status or geography.

But we're seeing extremely high patient satisfaction at 96%. Both our pre-term and our low birth weights are under 6%. Breastfeeding is at 83% and this is representing about what our sites consider 20% of women who could be in centering. So we do have many sites that are struggling with scaling up due to various constraints whether it's space, availability of providers to do centering, or all kinds of outside forces that are hampering scale-ups. So what we work with sites really closely on is challenges for enrollment, challenges for scaling up, and helping them to really make this model available to more women so that we can see these outcomes for all eligible women not just one in five.

John: I would just like to point out looking at this slide that we omitted the M on this and just so you know this represents about approximately 11,000 women involved in these results.

Tanya: Yeah, so approximately about a hundred per site that they're reporting on. So based on kind of what we've learned about centering, about how it is based on satisfaction not just patient satisfaction but also provider and staff satisfaction with better care. We have much better outcomes in centering compared to traditional one-on-one care and this all translates into an incredible cost-savings to the health system in general. This is what we're talking about when say that centering is really nailing the Institute for Healthcare Improvement's triple aim.

Centering Counts, the data system tools are built around the triple aim and being able to communicate and reinforce that centering is hitting all three. Some of our partners which should look familiar to you over the years, March of Dimes were absolutely integral from the very beginning of centering and the establishment of the institute in the '90s and have helped fund practice sites across the U.S. over the last 10 years to the tune of over $9 million.

We are in Answered Innovation and participate in many programs with AMCHP. Our current board president is a former ACOG president as well. We're very

closely tied to the ACNM, they provide CEUs for our workshops, many of our faculty are members and we work with them on many collaborative projects. Recently we've been working with the ANSOM Foundation to build the Centering Counts system online. Another important partner that's new to use in the last couple years that I'd love to mention is the Kellogg Foundation which is helping us really identify areas of need for centering in the country, where there may be small resources and help identified some new places for us to bring centering with some very focused help by looking at regions.

John: Which transitions us into where is centering around the country? So centering was first piloted at Yale in 1994. A informal rollout of the centering model didn't start until 1998. But today we're at nearly 400 practice sites across the country. This map represents the 200, almost 200 sites that we have that are approved sites which means they have met our credentialing standards. However, what's more interesting is the distribution of these sites because the other 200 sites are pretty much along the same distribution so you can see that there's a concentration in the Northeast, the Southeast, the Rust Belt, Texas, and then the West Coast. So that just gives you an idea of where we are.

Now just how does the Centering Healthcare Institute fit into all of this? Well, we were founded by Sharon Schindler Rising who started the centering model at Yale and has worked tirelessly to roll this out for the last 20 years or so. In 2001 we incorporated and became a not-for-profit organization. Our role with centering is we are curators of the centering model, we provide readiness assessments for sites, we help them determine if centering is a good model for them. We help with implementation, we've learned from working with hundreds and hundreds of sites over the last 15 to 20 years what the implementation challenges are in the healthcare system.

We provide training and facilitation skills that are needed to run centering groups. We provide curriculum materials so that it's a turn-key solution. We provide the Centering Counts which Tanya has already talked about which is the quality assurance portion of it. Then we also do the advocacy at the state and federal levels. One of the major pushes we're doing right now is trying to see if we can get payers to provide enhanced reimbursements for centering and that is something

that we've been successful in doing in South Carolina, in Louisiana, in Texas, and several other states. Minnesota's looking at it.

That sort of segues us into just a brief discussion about Strong Start which is a CMS initiative to evaluate different types or prenatal care models and centering is one of the models that's being currently evaluated by CMS and the Strong Start Initiative that's now in year, I believe it just started year three of that initiative. So we're hoping that in about a year and a half or two years we may have actual data and results from that study that support what we've been showing you today as our outcomes as well. So we've seen that centering is evidence based, it uses standardized approach to care, it reduces health disparities, especially among women of color, and offers accountability through Centering Counts. I think those are all targets for the Healthy Start program these days.

So we started thinking about how can Healthy Start use centering and how can centering help Healthy Start? So we don't know how many of you are actually involved in direct prenatal care but we suspect most of you are probably not. However, there are ways that Healthy Start could engage with centering such as helping to identify potential new centering providers in your area. One of our challenges is just getting the word out to providers that centering is working and we're here to implement it. Healthy Start could assist with initial start-up and provider training via hosting training workshops or providing monies for materials for sites or for patients or that sort of thing. Healthy Start could promote centering in the community. One of our big challenges is patient education about what centering is. When they come in for care sometimes it's new to them and the providers have a hard time getting them to accept centering care because it's new and unknown.

So normalizing centering in the community would be a great way to go. Then of course there's this whole aspect of supporting existing centering practices if you are in an area where there are centering practices. Every centering practice could use advocates for centering there to talk with the patients, to follow up with your patients. Case managers to reach out to patients about centering, provide transportation, childcare, and even to bring in our resources to the centering groups. Such as breastfeeding, lactation support, or other fun things that the group can do. Some groups do hula dancing for example.

Tanya: And self-defense.

John: And self-defense, just to break the tension and to provide something interesting for the group. So those are a few ideas. I'd just also like to share a small anecdote, we have a healthy mothers healthy babies coalition down in Palm Beach County, Florida, that's very much like Healthy Start program in that they don't provide any direct prenatal care. What they do is they actually rent space at one public health clinic and then at another private OB practice and they contract with the OB providers to come in and be their providers in the centering groups. But the healthy mothers healthy babies actually runs the centering practice. Because they have community outreach vehicles they're bringing women into the centering practice, they're enrolling them, they're managing the groups, and then they're bringing the OB providers into actually co-facilitate.

Then healthy mothers healthy babies does this facilitation training, or brings us down to help do the facilitation training, and make sure everyone's on board. It's a great model that works for them in their particular circumstance. They're funded in a slightly different way, they have a tax-overlay district so they get some funding just through sales tax revenue. But conceptually what they're doing seems to fit very well with the Healthy Start grantees.

Tanya: Yeah, and it's important to note for you all on the phone is that the model can be rolled out and implemented in a number of different settings and in a number of different ways. We're very creative and flexible here and we would love to talk more about how it's happened in the past, the lessons we've learned, and how it could happen in new ways in the future, to work with different communities and how care is provided in them.

John: Great. Whatever the next step should be for you would be to contact us for more information. CHI is here to help in whatever way we can, and you saw with implementation, with ideas, sharing information about what's going on around the country, and how others are doing it. That's our main goal. We try to work as connectors for the rest of the communities out there. With that I think we are done and we can take any questions that people have.

Megan: So if you have any questions or comments please chat them into the chat box and we'll have some Q and A. I do have a question here for you, John and

Tanya. As a Healthy Start grantee organization that doesn't provide direct service, how can I find provider partners in my community?

John: Okay. So that gets back to the example that we were just talking about. So how do you find providers? Well, I think the first thing you would need to do is talk to us about understanding what to look for in a provider.

Tanya: We may know them.

John: Yeah, we may have some leads in that community already, folks that have expressed interest in centering but haven't been able to line up the funding to do something, to start it on their own. We certainly can help with being able to understand the qualities of a practice that are going to make a better centering practice. Patient volume is certainly a key component to this. So we generally recommend that a practice see about 150 new OBs, at least 150 new OBs a year in order to have enough volume to fill centering groups on a regular basis. But the first step would be definitely to contact us for more discussion about the best way to approach that.

Tanya: And some ways we've been successful in doing that in the past was with Healthy Start grantees is working with the agency that is getting the grant to then release an RFP, generate some interest in the community, maybe hold an event to help folks become familiar with centering that would then inform their RFP. Then we can also provide technical support to them in the RFP development, in the review and assessment of the potential interested sites. But that key really is finding the practices in the community that would welcome the idea of transforming care to groups and having them be your partner as part of the Healthy Start grant.

John: Then Tanya makes a really good point about events because we offer an information seminar. So one way to reach out to the community is to invite us down to conduct an information seminar and send out invitations to some of the OB practices in the area to come listen for a couple of hours about the centering model.

Megan: Great. So a couple of questions about the centering sessions and the setting. Does centering have to be done in a clinical setting?

Tanya: It actually does not, but that is very dependent on the payer. We do have many centering practices that do what they call community-based centering where the actual care sessions are happening in a school. Maybe they have teen patients that are more likely to come to their appointments if it's held at their school. Some are held in community centers and religious-based organizations. What's key to community-based centering is that it's still reimbursable by the payer. We do have some practices where they are restricted from doing care in "non-clinical areas." So a lot of that, the answer to that question, lies with the payers. But the model itself, the way it's designed is anywhere that care can happen where there's a space that feels comfortable, private, like it's not flap-dash. Like it is where you're receiving your care and the provider team can meet with women is fine by us.

Megan: Now, does the provider stay for the entire group session?

John: Yes, yes. That's actually one of the requirements, one of the 13 essential elements. Because when you think about it the women in the group are pooling their time with their provider. So the provider's getting paid for a visit with each one of those women. So really there's almost an obligation to stay there with those women because the provider's being paid to do it. But it's also, the provider becomes part of the group. That's what's essential. They're not the provider, they're not an authoritarian figure. They are one of the members of the group, involved in the discussion, and they help to correct any misinformation that happens in the group. But they're not there to be didactic or directive to the group. What they do, it's important that they become integrated members of the group. It makes a huge difference for both the providers and the patients.

Megan: So can there be a co-facilitator with the group provider? And who would be a good recommended co-facilitator?

Tanya: Yes, and thanks that's a good question. We get asked a lot about the co-facilitator. Who actually fills that role is very flexible. The most common folks that we see as co-facilitators are nurses or medical assistants, childbirth educators, social workers. They're meant to truly co-facilitate with the healthcare provider. So it may be that for some group sessions or some content areas the co-facilitator is actually leading the facilitative discussion. You know, our hope is that the provider

team actually shares as much of the facilitating responsibility as possible so that it does feel participatory.

We understand folks have different personalities and facilitation styles so it really is one of the wonderful things about centering. That you're not on your own leading a group of 10 or 12 women and their support people. But that you're part of a facilitation team and then you can debrief after group to talk about how things went and plan for the next one.

Megan: Great. So here's a billing question for you. Since the provider is conducting this as a visit, is it classified as educational or otherwise for billing purposes?

John: Yeah, this is one of those, it depends on who your payer is and what state you're in. So, right now it's billed as a normal prenatal care visit. With some payers you can bill another educational line to that. We're not billing experts, only because there's so many jurisdictions and so many payers that we don't know it all. But we do know that some of our sites are, billing is a very common question and so there are lots of codes that get batted about by the practice sites. One of the purposes of our centering consortia that we pull together in our space, for example we have centering consortia in North Carolina, South Carolina, Virginia, D.C., Maryland, New York, who am I missing? Georgia.

Tanya: Ohio, Wisconsin, Indiana.

John: Ohio. Yeah, Indiana. I mean we encourage local centering consortia to bring the practice sites and the stakeholders together including the payers so they can talk about these issues amongst themselves. So this is again one of our sort of policy goals at the Centering Healthcare Institute is to build supporting networks of centering practices to help support each other in state or in region.

Tanya: And understand, the codes that are available to them right now currently to bill for the extra service that are happening in centering, but also look toward a future where it's enhanced at a higher rate because the payer is enjoying the savings from having fewer NICU admits and fewer pre-term births.

John: Right.

Megan: This next question kind of goes back to your slides, slide 18. But it's specific to Healthy Start. As a Healthy Start project could you give more information about how Healthy Start could assist a centering program if the program is not a centering project? So I'm gonna go ahead and take you back to your slide 18.

John: That's fine, yeah.

Megan: You may have some ideas.

John: Well, I'm trying to get a handle on, could a centering program if the program is not a centering project. So I'm looking for a little bit more clarification on the different between program and project.

Megan: Janice, if you want to provide a little more explanation of your question, but what I'm guessing is if they're not using centering as a model through their Healthy Start grant, but they want to be involved in centering, the centering program, how would they do that?

Tanya: I love that that question was raised. Thank you. Because it kind of feels to me like well, if we, you know if this isn't part of the description of the project we're working at how can we help anyway. I mean, I think that's something where John or I could have a conversation about where you're calling from, what centering is happening in your community, what are the sites struggling with, and that's maybe something where a promoting center in the community would be very, very helpful.

I mean, if we're all, you know, partners in the MCH world how can we help increase referrals to centering practices, help women understand what it is so that they seek it out, ask for it, and understand the benefits of centering. I mean what we really want to do is empower women to understand that they have a choice in care, that this is a model that offers much more than individual visits and if it's available in the community we want them to seek it out.

So we would love to talk with anyone who's coming with an interest and enthusiasm and maybe not a directive as part of a project but about how they could help. Yes, if they don't provide a direct answer. Thank you. Yes, I think that's what we were understanding as well. We have many really creative partners out there

working on centering. We have groups of doulas that are working with centering practices that were not affiliated before they began doing centering and were looking for co-facilitators. We have many, many community partners that are working mainly in this area of promotion and helping kind of drive women to where centering is offered.

John: I think that there's a lot of commonalities among centering practices out there, if you're talking about how can you support an existing centering practice. Patient enrollment and retention is, retention's not so difficult if the patient enrollment is done correctly. But patient education and outreach to the patients to get them to group, remind them about group, their appointments, is something that every practice could use support with.

Tanya: Yeah.

John: You know?

Tanya: And also, where we have communities that have kind of what we call care-deserts where it's very difficult for women to actually get to care, there are geographic barriers, there are transportation barriers.

John: There are childcare barriers.

Tanya: Childcare barriers. You know these are all areas where community agencies could really partner with practices to help get women to care.

Megan: And Healthy Start Rochester just gave their example which I think is great. They've shared that they aligned their Healthy Start case management at centering pregnancy sites to reinforce and promote improved health and birth outcomes. Including care coordination with centering providers and follow-up. So thank you.

John: Great.

Tanya: Yeah, Rochester is a fantastic example. Thank you for that. They have been doing a tremendous amount of work over the last two, three years to really bring centering to the entire community by a multi-site rollout.

John: And here in Boston, we have our own Healthy Start centering initiative in Boston. So that would be one to look into as an idea for a model for outreach.

Tanya: Yeah.

Megan: And she shared some further detail. No, it's really great, Healthy Start Rochester. So I appreciate it. Let me just share it with the group. It says that, "We also link community-based doulas to centering moms in need and introduce benefits and make connections via centering providers." They link nutrition education and demonstrations before or after centering pregnancy sessions to provide additional support in food choice, preparation, healthy shopping in an affordable way, etc. So, really great, great example.

John: Yep.

Tanya: Yep, I mean that's what we love to hear and one of the beauties of the model is that once you have women together how you can support them and interact with them just grows exponentially. You imagine across 10 sessions the connections you can make and the support that can be provided. That's just a missed opportunity at one-on-one visits.

Megan: Great. So folks I'll give you a few more minutes to ask any questions, but while I give you a few more minutes why don't I just go ahead and do a couple of reminders about some other upcoming webinars that we have that you can mark your calendars for. If we don't have any questions after that point we can wrap up. But, so on May 5 there's a webinar on the quality family planning recommendations that have been developed through the CDC and the Office of Population Affairs with respect to Healthy Starts. That's May 5th from 3:00 to 4:00. On May 12 from 3:00 to 4:00 Eastern there's a part one webinar on how to talk to parents about breastfeeding, starting the conversation.

Part two and three of those webinars we're going to record so that folks can then follow up and listen to it at a later date. From May 13 from 3:00 to 4:00 Eastern there's a webinar on collective impact, launching our learning together. That's gonna review the peer learning networks that we'll be setting up where there'll be a lot of intensive information shared about collective impact. That's May 13. On May 14 from 3:00 to 4:00 there's a webinar on male inclusion and fatherhood, why is this important and readiness strategies for staff and organizations.

Then on May 19 from 3:00 to 4:00 there's a webinar on domestic violence, screening and follow-up. All of the registration for these is up on the Healthy Start Epic Center website along with any archived webinar information. We do want to remind you all that attendance is not required for these, but we really encourage you to delegate and share this information with your other Healthy Start colleagues that the content is relevant for.

So it doesn't look like, John and Tanya, we do have any more questions in the hopper. But I do want to really thank you for the great information you shared about the centering pregnancy and centering parenting models. We really appreciate this, and I'll go and put up your contact information here, and if folks if you have other further questions Tanya and John's e-mail address is here and their phone number is here, too. But with that I'll just thank you again and thank you all for your participation and your time in the webinar. That concludes the webinar and I wish you a great rest of your day.

John: Thank you, everyone.

Tanya: Thank you, Megan. Thank you, everyone.