THE BLOODLINE WITH LLS

A PODCAST FOR PATIENTS AND CAREGIVERS

Episode: 'How Will My Child's Cancer Diagnosis Impact Their Emotions?'

Description:

When you think about a pediatric patient, they are not a child living in a vacuum. They are part of a very complex system that is suddenly impacted by a cancer diagnosis. Psychosocial care helps to address every piece of that complicated system to successfully get patients the treatment that they need. Join Alicia and Lizette from The Leukemia & Lymphoma Society (LLS), as they speak with pediatric oncology social worker, Chelsea Keeler, from the Children's Hospital of Philadelphia. Chelsea provides services to patients and families to help optimize functioning, such as psychosocial assessments, supportive counseling around disease diagnosis, coping, decision-making, and connection to community resources as needed. On this episode, they'll discuss the growing field of psychosocial care for pediatric patients, how psychosocial care differs between children and young adult populations, advancements in technology that have improved how support is provided around the world and the role of a psychosocial team and their relationship with patients and families.

Transcript:

Alicia: Welcome to "The Bloodline With LLS." I'm Alicia.

Lizette: And I'm Lizette. Thank you so much for joining us on this episode.

Alicia: Today we will be speaking with pediatric oncology social worker, Chelsea Keeler, at the Children's Hospital of Philadelphia. Chelsea provides services to patients and families to help optimize functioning.

Those services include psychosocial assessments, supportive counseling around disease diagnosis, coping, decision-making, and connection to community resources as needed.

We're so glad to be speaking with you today.

Chelsea Keeler: Thank you so much for having me.

Alicia: Great. Now before we jump into discussing today's topic, how did you become interested in the field of oncology social work?

Chelsea Keeler: Absolutely. So I initially, when I was thinking about what I wanted to do with my career, thought that I wanted to be a nurse because what an incredible profession, but realized that the blood and vomit and many of the most wonderful things that they do were not really in my cards.

So, I then shifted my focus a little to more of the helping profession, like what you can get from nursing without that medical piece and felt that I wanted to be a sit on my couch, tell me your feelings type therapist. But when you think about what social work can do, which is so cool, we do have so many aspects of therapy in what we do, but we get to touch on every piece of the puzzle, not just mental health or how patients and families are coping with what they're going through.

So that was what drew me to social work initially. Then working with the oncology patient population is an incredible privilege. It is a department here that is so full of hope and light and resilience and immense caring that makes what I do every day feel like an honor. So that was how I ended up in this department.

Alicia: That's so interesting. It's so funny to hear that because my cousin, she is a surgeon now, and she said that her first day when she actually had to go in and shadow a surgeon, she fainted. And the surgeon as well as our family was like, "we think you may have chosen the wrong profession." But she got over that pretty quickly, so it's always interesting when there's theory and then there's that practical sense and you're like, "Can I actually do it? Is this exactly what I'm doing?"

Chelsea Keeler: Absolutely.

Alicia: Now, shifting gears to the topic for today's podcast, we always talk to patients and caregivers, about when they received that diagnosis and the impact that that diagnosis had on them as well as each family member or loved one socially, emotionally, all the different factors involved. And the term psychosocial care is one that I feel is relatively new in regard to how people are understanding that. Would you say that's correct and can you explain what that is for our listeners as well?

Chelsea Keeler: Absolutely. So, yeah, I think medical care feels more easy to understand when you think about medical conditions, that there's something that's going on in your body and you need treatment to get better from that.

Psychosocial care is looking at every other piece of life that is impacted by this medical diagnosis. So it kind of goes hand in hand with the medical in that way because when you think about a cancer diagnosis and the amount of time that a patient may spend actually receiving medical treatment, for example, how much time they're actually taking chemotherapy or how much time they're actually getting a blood transfusion, that is so small compared to the amount of time they spend dealing with all of what we'll call the psychosocial factors. And so that's why this focus on psychosocial care has become much of a big piece of what we're talking about is because the psychosocial impact of cancer treatment greatly exceeds in a lot of ways the time that we're spending in the medical care. So psychosocial care it's vast.

When you think about a pediatric patient, they are not a child living in a vacuum alone. They are part of a very immense, rich, complicated system, and that entire system is impacted by a cancer diagnosis. And so, by that I mean they may live with some family members. Okay, every one of those family members is going to be impacted by this diagnosis. Parents may be working. Now they may not be able to work to the same extent that they were working beforehand. Are they allowed to take that time off? If they can take that time off, is that paid time off, is that unpaid time off? If it's unpaid time off, can they afford to take unpaid time off? Does that time cover the amount of time that they'll need to be with their child in treatment or does it only cover a small portion of the amount of time that they'll need to be in treatment?

Then you look at the child who may be in school. We'd, obviously, like them to continue in school. School's very, very important. So, can they still go to school? How much school will they be missing? If they're not able to go to school, can they be taught what they need to learn at home?

Their siblings are used to the life that they were living before their sibling got cancer, how are they coping with that? Are they still able to go to school and succeed in school? Do they need certain accommodations to be able to do that?

Does this patient have insurance? Does that insurance cover what it needs to cover? And on and on and on and on.

So psychosocial care is meant to touch on all of those pieces because every one of those things in the system – does the family have a car, can they use the car to come back and forth to treatment, can they afford to put gas in the car? If they don't have a car, how are they going to get back and forth from treatment when some treatment may be multiple days a week for weeks or months or years on end?

So psychosocial care is meant to help address every piece of that big, huge, complicated system because addressing those pieces is ultimately how we successfully get patients the treatment that they need because everyone's goal when we sit in a new diagnosis meeting and, unfortunately, have to tell a family that their child now has cancer, the goal of everyone is to successfully get to the treatment they need.

And I don't mean success meaning that they'll be cancer free again because for some families that may never be the reality. But I mean success where, if they need treatment or treatment would benefit them, can they access it, and can they do it? Because if we have great medicines that help cure diseases, the patients need to get to the treatment in order to be able to just benefit from that. And so, all of those system pieces impact the ability to get to and from the therapy that they need.

And so, part of my job, when I meet families at diagnosis, is to understand that very complicated system that they live in and understand all of the aspects of their life that may be impacted now by this diagnosis and the demands of treatment.

Lizette: Wow! I know that we could spend hours just on the psychosocial issues for the patient. But I just want to thank you for involving everybody that is involved – all of the caregivers, family, friends, everybody that's part of this. A lot of times we forget about caregivers. We forget about all these issues that you're talking about surrounding the patient and we're so into the patient care. So, I want to thank you for really reminding us that it's not just the patient.

Chelsea Keeler: Yeah. And I don't think that that's unique to pediatric care, although there certainly is a piece of pediatric care that is different than the adult care in that children can't consent for treatment by themselves. Depending on their age, they likely can't come to and from treatment by themselves. They may not be able to take medication on their own. They may not be able to do activities of daily living on their own. All of that could be true for adults too. And so, you see the involvement of family so much more presently in a way that's not optional. And so, we need to make sure that we're addressing all of the family's needs because, for example, let's say a patient doesn't come to their necessary chemotherapy treatment. It's easy to assume, okay, they're not there. Maybe their parent doesn't care. Maybe they don't think they need it. But most times what I found in my work here is that it's actually based on a barrier that we maybe don't even expect.

So, for example, let's say a single parent was working before their child was diagnosed. Unfortunately, does not work in a position where they're protected by Family Medical Leave, which is a federal program that you can only access if your company is big enough and you've been there for enough time and you work enough hours. So they may not be eligible for that leave, so that means that if they exceed or use up all of their personal time, their employer is within their rights to say, "I'm sorry, I have to let you go."

So now that parent is unemployed and may not be making the money that they were making beforehand. And now, suddenly, they haven't been able to keep up with their car payments. They've had to turn back in the car and now they don't have consistent access to transportation. They had plans with a friend to bring them. That friend, unfortunately, fell through and now the child's not at their therapy appointment.

Now that, to me, so very clearly is not a lack of caring or not a lack of understanding the necessity of the treatment. That is a concrete barrier to getting to and from therapy. So then that's where my assessment and my involvement as their social worker would come in to say, "What other ways or what other resources do we have access to that we can use to help you get to and from your appointments? Can we access something through your insurance in order to get you to where you need to be?" And then, suddenly, that compliance issue is not an issue because we've assessed for and addressed the barrier to why they weren't coming to their necessary care.

Alicia: Chelsea, you make such a great point in, in saying that many times people might assume what a family situation may be. And I think it's so great that you are highlighting that and bringing that to the forefront on this podcast.

In your experience, what are common concerns that you hear from families or patients that our listeners may benefit from?

Chelsea Keeler: Oh sure. So I think commonly, really, what we're seeing, which I think we could assume is one of the biggest concerns when a child comes in and families are being told that they now have a new cancer diagnosis and are going to need intensive cancer therapy, is "How am I going to pay for it and how am I going to afford it?" which is a huge, huge piece. The financial stress that goes into cancer therapy is prominent in both the pediatric setting and then also prominent in the adult setting, as we all know. So, it's how I'm going to pay for it.

Something that comes to mind that I think, to me, feels a little bit unique in pediatrics is that when a child is diagnosed with cancer and their parent needs to take time off from work to care for them, which we can all understand – they need to bring them back and forth from appointments, they need to give them their medicines at home, they need to watch them for fever which can be life-threatening, they need to help them with their activities of daily living at home, provide emotional support, all those good things – when that parent needs to take time off from work, most employers and most companies don't allow parents to access their sick time. Or, for example, parents can't use their own disability leave to provide care to someone else, which is different than if you as an adult are diagnosed with cancer and now you're too ill to go to work, there are different things that you can access to help offset the fact that you're not at your job. Parents are not paid to leave their work to go provide care to their child. If they're able to, they can access protected time off from work through Family Medical Leave, but that just means that you can't be fired from your position in that 12-week window, which is what the federal program gives us, but most employers will not allow you to access your paid time off if it's for your own illness.

And so that is a unique need to me in this patient population because being away from work and not having the paychecks that you're used to getting is a massive financial stress on top of now potentially increased copays, the gas of coming back and forth, food in the hospital, bridge tolls, etc., etc. So I think, primarily, one of the biggest stressors we see is, "How am I going to pay for it? How am I going to do this?"

And then like every good parent thinks is, "What am I going to tell my other kids? How am I going to make sure that this patient's siblings are supported while maybe I'm used to being at home and now, they're not going to see me at home as much because I'm with my sick child in the hospital?"

Lizette: Right. And, also, I mean you're talking about all of the logistics. I know as a parent; I feel that my head is full just with all the logistics of the routine for my child. So just adding another routine on top of that and having a treatment team, having a social worker, having someone that people can rely on, you know, for these logistics, even to think of it. I think it's really important that people know that they can reach out to their treatment team.

What I mean by that is to really ask for a social worker, ask for a nurse, ask for somebody that's part of your treatment team that could really help you with all of these questions, all of your concerns, planning. And then what you're doing, really, Chelsea, is you're highlighting all these barriers that people don't think of. And I know that most of the time when you're in a doctor's appointment, you're in with the doctor, you're not thinking about asking the doctor or telling the doctor about any of your barriers. You're just listening to see, you know, how your child is doing.

Chelsea Keeler: Yeah, absolutely. I encourage everyone to reach out to their psychosocial supportive team at their center because this is exactly what we're here for to address all of those other barriers.

In 2015 there was an article that was published in *Pediatric Blood Cancer* that really worked to standardize and create standards for psychosocial care of children with cancer and their families because there is an incredibly large body of research that talks about the psychosocial risks for children and their families during and after cancer treatment, but there is also significant variability in what psychosocial services are offered in different pediatric oncology centers.

So, you may have a center that has a very well-staffed social work, child life specialist, or a music therapy team and then you may have a center that doesn't have a social worker at all and you would just be communicating with a nurse.

And so, the goal of this was to develop evidence and consensus-based standards for pediatric psychosocial care. And so that article actually lays out 15 standards where the goal would be that this would be adopted that any child and family receiving oncology care in a pediatric setting in the US, hopefully, would have access to these 15 standards worth of psychosocial care.

And so, obviously, that is a massive step for some centers that may not be as psychosocially well-staffed right now. And then for some centers, like at CHOP, we were meeting all 15 standards when these were published. So I do encourage everyone to reach out to their psychosocial team to ask for these supportive things because we do know that cancer treatment has immense psychosocial impacts both at diagnosis, throughout treatment, and then sometimes even more so at the conclusion of treatment because you've had this supportive team throughout treatment time and now your family's transitioning back into what we quote/unquote call "normal life." But normal life doesn't look anything like it looked before and your family's been through immense trauma, a huge change in how you function together, how you do your day-to-day living. And then, suddenly, you're not seeing your supportive team as much, which is a good thing. That, hopefully, means that your child's doing better and doesn't need that level of medical care, but now you're kind of thrown back into the real world completely on your own. And so, these standards work to lay out what family should have access to throughout the entirety and then after their child's cancer treatment.

Alicia: And you bring up a great point regarding after cancer treatment might be completed How important is it for families and for patients to know that even after treatment, attention to their psychosocial care must be at the forefront and must also be taken into consideration as well?

Chelsea Keeler: Yeah, it's immensely important. And sometimes when you think about families functioning in that fight or flight mode, you kind of kick into fight mode when your child is diagnosed and you need to get through this intensive treatment, you're juggling even more things than you were juggling before, and you just find this way to muscle through it.

And then treatment ends, and sometimes that, for many families, is the first moment where you take that breath and say, "Oh my gosh, what did we just do? What did we just go through as a family?" And that can be when the waves of grief and overwhelm and anger and sadness really start to wash over that caregiver that just powered into "I have to do this right now" mode when their child was in intensive therapy. And so that can be the most vulnerable and most difficult moments.

And then also transitioning into a time where you don't need to respond to every fever or every sneeze with the same level of intensity that you had when your child was in active chemotherapy treatment. How do you trust again that that bruise doesn't mean that they could be relapsing? But it also could mean that they're relapsing. When do you bring them back into the doctor to get seen? What do you treat as a normal my five-year-old is going to bump into things and then may get a bruise?

So, it's hard to feel like you can just take a sigh of relief at the end of therapy. I say to families, when I'm working with them as they're about to transition into end of treatment, that it's, unfortunately, not just like turning a light switch back on. That you had put your life on hold for this series of months and then, suddenly, you just flip back on the life that you knew before your child was diagnosed because, unfortunately, that version of your life doesn't exist anymore. There is no way to go back to the way that your life was before your child was diagnosed. There's just the work now to try to find your family's new normal and what does that look like.

Alicia: But I remember a patient that I was talking to on a previous podcast, they were saying that when they were diagnosed, it was such a shock to them that they kind of said to themselves, "Okay," like you said, "all hands on deck let's do this." And then at the end of treatment, thankfully, they were in remission and they were so happy to be at that point. But because it was so different, she needed a whole different team around her in regards to adjusting to that new normal because now it's kind of just a transitional period at this point and it's no longer just I had cancer and now I don't. It's I had cancer, this is who I am; and at this point now, what services can I benefit from that can help me get through this?

Chelsea Keeler: Yeah, the identity piece, too, that you touched on a little there is so interesting because for that time that patients are in intensive treatment, your identity is cancer patient, right. And then when therapy ends, where does that fit into your identity anymore? Now you're not really the old version of yourself; you are a person who had cancer. That cancer treatment can have immense impacts medically alone on your life moving forward and then reintegrating.

We look at children who maybe missed most of middle school and then, suddenly, they're rejoining their peers in high school. Well, those relationships have continued to morph and mature and grow and evolve over the years that that person may not have been in school. They may have learned the actual concrete materials that they needed to learn over that time, but then where do they fit back into the people that they used to know, and how do you handle when the person who used to be one of your best friends is complaining that their nail polish is chipped and you're flashing back to when you were in the hospital, nonstop vomiting, about to go under your tenth lumbar puncture and couldn't even see straight. And how do you empathize with that person? How does that person empathize with you when they don't understand any of your experience in that way? And so that transition is huge and can, for some families, be more distressing than the transition into therapy and into a new diagnosis.

Alicia: Absolutely. I remember another adult said that he would walk, after everything, he would walk into a supermarket and there was one time where he was with his mom or somebody, and he just kind of stood there for a while. And he said- And, of course, we don't know the stories of everybody in the supermarket, but what he said to himself was, "Everybody is shopping for groceries and like it's just a shopping day for them." And he had just come out of the most challenging time of his life. And, and, to your point, it was that identity of I really can't relate to what's happening right now

Chelsea Keeler: Right, and that, it's part of why we focus so much on trying to offer opportunities. Like we have several support groups here at CHOP, opportunities for patients to connect with each other because so often even the best-intentioned friends or family or community members on the outside just don't understand so much of the reality of what being in treatment looks like or means. And so connecting with a peer who you can still talk about the normal stuff with but also understands what it's like to be so nauseous, or to be in so much pain, or to go through all the things that patients go through in the hospital, can be so, so supportive in a way that friends just don't understand, or that random person in the grocery store just doesn't understand.

And, yeah, sure they could be going through their own things too. We don't know what their life like outside of here. But it is hard not to get overwhelmed or just totally taken aback by life went on while I was in therapy, and now I have to find some way to catch up or mesh back into that, and I don't really know how.

Alicia: You mentioned peer-to-peer resources that, that are becoming more and more available. What are other resources that pediatric patients and their families can be made aware of that could help them during this time?

Chelsea Keeler: Well, something that's cool, you know, as we've moved further into the technology age is that support doesn't necessarily look so much exclusively like sitting in a circle and introducing yourself and talking about your feelings, which can be so supportive for the type of person that benefits from that type of support. It's wonderful.

But there are so many people, particularly with the patients I work with who are younger or just don't feel like they really want to be that formal or that open, they can benefit from support in different ways. So for example, an art therapy group instead of a sit and talk group can be a way that conversation comes out so genuinely and so honestly; but you're not sitting staring at each other, you're engaged in an art project. So different mediums in that way that can bring out support in less traditional but equally supportive ways.

There are all kinds of ways to connect on the Internet now. You know, we have a list of resources on our website that are ways to connect with peers that are not in person or face to face. You know, we're piloting a program here that is a peer-to-peer mentoring program that can also be done through text message. So instead of having to formally meet up with some regularity, which in today's scheduling can be so difficult, you could reach out in a moment where you are just feeling a little bit more down and then get that support through text, which is how most teens are communicating anyway.

So it's cool to watch these things kind of grow as technology is changing, even looking at programs that could help with compliance that are text reminders or an app that you engage with that reminds you to take your daily medicine that you get some kind of reward for when you do it a certain amount 'cause that's what we're getting from a lot of our cell phone apps anyway.

So, it's nice to see different types of support coming for people who need support in more creative ways. Even something like a music therapy instead of just talking can be…

Lizette: Sure.

Chelsea Keeler: …something that's more easily accepted by people who cope that way.

Lizette: Hmm hmm.

Alicia: Absolutely. As society changes, our resources have to as well or else we're kind of in the background and the people aren't being helped as successfully as they would have been or should be.

Lizette: Right. And I know that you're in Philadelphia, which is, you know, a big city and there's a lot of resources there, but also web-based support systems are great for people that are in rural areas that may not have large centers or many people around them that might have the same diagnosis or same experience.

Chelsea Keeler: Yeah, that's such a fantastic point because if you're driving three hours to your cancer center, you're not going to drive an extra six hours roundtrip to take advantage of a one-hour support group. Although it may be that helpful, that is so much time and resource for a family to do that. So, you're exactly right, having online or app-based supports means that people can access it no matter where they are.

Or also what time it is. I say to families, to parents when I meet them on the floor, "Sometimes like the most pressing questions or the deepest stress comes at 11:30 PM when it's finally quiet and you finally have a moment to lay down and process what happened during the day." Which is even something nice about if I give families my email address, I say to them, "Email me your worries at 11:30 and I'll respond the next business day." But then you can get them out when you're thinking about them and, hopefully, that release means that you can relax and try to get some restful sleep that night.

Lizette: Sure.

Alicia: Absolutely. And for those listening, if you would like to see more of the support resources that LLS offers, you can visit www.LLS.org/support and you'll see, for example, this podcast and the other episodes within this podcatcher channel as well as our online chats, our booklets, our one-on-one nutrition consultation, and other resources. So, again, that Web address is LLS.org/support.

Lizette: And, Chelsea, I was curious. I know that depending on the age of the patient, usually there's some adherence issues with getting to treatment. Usually they say that the smaller children because the parents are there to, hopefully, get them to treatment, there's more adherence. But once you get older to the adolescents, more so the young adults, that sometimes it's harder for their adherence. And I know that you mentioned that there's some apps that can help out with that. Do you find that more of the younger patients with their families are taking more advantage of psychosocial resources, or do you find that at every age range they're taking advantage of these services?

Chelsea Keeler: So, I think it's a complicated question although a good one. There are many teens and young adults who do take advantage of psychosocial resources. I think we also recognize within the pediatric setting that some of our resources are more structured for the younger age group. You know, I sometimes say to families that I'm working with that the 4-year-old who comes in and is getting cancer treatment has a different understanding of what they're doing and what they're going through than the 16-year-old.

And so, when we have a music therapy group in our playroom, we can take the 4-year-old and they may bang on a drum for an hour and be completely oblivious to the fact that they're receiving chemo through their IV at the same time. What's harder about the 16-year-old patient is that that 16-year-old is extremely aware of what's happening in and on their body. They're aware of everything that they're missing and everything that they've lost in their life, which is also something that social media really brings to our attention all the time. So, they know that their friends are at the prom right now and they're stuck in the hospital and they're not there. And so, I don't have a way to fix that or to make that go away. And so, their needs are just so different and it's just harder to touch and to make better.

So, in taking it back to compliance, I think that compliance in the young adult population is very complex. And some of that may be understanding health beliefs of that patient population and helping explain why we think this medicine is necessary even though there's no evidence of cancer in your blood or in your bone marrow, but we understand that this would be important for the long term. Like addressing that complex that like, well, no, I feel fine now. I'm fine.

So, there's a lot of work to be done there. And one of the nice things about having oncology-specific psychologists and neuropsychologists on our team means that they understand the unique needs of that patient population in the oncology treatment world.

But some of it may also be the barriers. Maybe your parents are not as involved in getting you to and from therapy anymore because you live independently at college and now, suddenly, getting out of class or not missing class where missing one means you may fail the semester is much harder, so getting to see your physician is much harder. Your insurance may have changed when you turned 18, for example, if you were on a state Medicaid program and so now, suddenly, your medications are much more expensive than they were before. That would be a significant barrier that you may not be able to afford it.

Going back to the example of college, maybe you don't have your car there and getting to and from your doctor is harder. Maybe transitioning to an adult provider now that you're out at school means that there, you don't get reminders of your appointments in the same way you used to, and that just means that it's easier to forget. There are many, many pieces that play into compliance as patients get older. Again, just in thinking back to does nonadherence mean no caring, so often that answer is no. It's just understanding patient needs as they adjust through the lifespan.

Lizette: What you said was so important, "understanding patients' needs" and, and letting the population know that you're understanding their needs

Alicia: Chelsea, is there anything else that you'd like to tell our listeners today?

Chelsea Keeler: My hope for every family who's going through cancer treatment with their child is that they don't feel like they're ever alone in this because that is, really, if we had to put a big, huge theme on what psychosocial care is for children in cancer treatment, it's that they are not alone. One of the standards that we talk about and what we're hoping every child and family has access to is this communication/collaboration with their team.

And so when you think about psychosocial care, social work is one piece of it, and we certainly hope to do a lot; but in the pediatric setting, we have child life specialists who are specifically certified and trained to help children understand what they're going through, understand what may be happening to their body, and cope with the unique traumas and stresses of cancer therapy. We have art and music therapists who can help provide support to those patients who may not benefit from more verbal support but also may not be able to engage in verbal support. They may not be at an age where that would be helpful for them, or they may not have the capacity to do that.

We have schoolteachers who will make sure that school proceeds on the path that it's supposed to and that children can, hopefully, successfully reintegrate back with their peers and their classes when they're finished with their intensive therapy. We have psychologists who understand the unique mental health needs of the oncology patient population. And so all of these specialists – we have chaplains who could help address religious needs and spiritual care needs. And so all of these specialists are advocates for patients and families. They're all just seeing patients and families through a different lens.

And so that unique perspective and approach of that entire team means that we are trying to provide the best most comprehensive support to families as they go through this experience. And so, I want to reiterate that no family should have to go through this alone. And even if you're receiving treatment at a center that is not as psychosocially well-staffed, there are supports available online through community resources, community groups that you can connect with other families. You can connect with supportive professionals to help provide support at diagnosis, throughout intensive treatment, and then as treatment is ending.

Alicia: That is awesome. Chelsea, thank you so much for explaining so clearly what psychosocial care is, specifically for pediatric patients, barriers that many families face, and how needs may differ within the young adult population, and resources available to families. I really hope that our listeners will be reminded just how helpful psychosocial teams are and their pursuit, like you said, their strong pursuit to provide the best care to their patients and to their families.

It was a really great conversation and thank you so much for being on today.

Chelsea Keeler: Thank you so much for having me. This was an absolute honor.