Episode 73: What Students Should Know About Becoming a Specialized Medical SLP (A Day in the Life of a Medical SLP Series)

Meet Jessica Durkovich, a medical speech-language pathologist who works in the intensive care unit. During her appearance on The Missing Link for SLPs podcast, she explains why teamwork is essential in the hospital setting, delves into the benefits of being proactive instead of reactive, and shares why her role is so rewarding.

Discussion & Reflection Questions

1. Can you tell us why you decided to become a speech-language pathologist?
2. How did you prepare yourself to move from private practice to a medical setting?
3. Can you explain what a general medical SLP does?
4. How many other SLPs are on staff with you in the ICU? Who else do you work with regularly?
5. What do your day-to-day tasks look like in the ICU?
6. What is it like when you first walk into a room with an intubated patient?
7. What is it like to extubate a patient?
8. What are some of the challenges of working in an ICU? The rewards?
9. Any words of advice for new or transitioning SLPs out there?

Quote of the Conversation

"Advocate for yourself. Advocate for our profession. We have a place at the table in the ICU. And it takes a lot of work. Get to know your physicians. Get to know the other team members in the ICU. And you can build a program that's successful in the ICU by working with the team. It cannot be done alone, but by working with a team, you can advocate for yourself and have a place in the ICU."

-Jessica Durkovich, MA, CCC-SLP

Jessica Durkovich, MA, CCC-SLP

Intensive Care Medical Speech-Language Pathologist

Jessica Durkovich, MA, CCC-SLP graduated from Ball State University in 2005 with a Master's Degree in Speech Language Pathology. Jessica's career-long passion has been caring for adults in acute care, with a specific love for dysphagia. However, since joining the IU Health Critical Care Rehab team in 2017 her focus has shifted to caring for the medically complex patients in the ICU, encompassing both dysphagia and cognition. Joining the Critical Care Rehab team has spurred a drive to learn more about Delirium and Cognition and the implications for critically ill patients. She has demonstrated passion and dedication while developing the role of the SLP as an integral member of the critical care team. Through this hard work, Jessica and team were awarded the IU Health East Central Region Values Team Leadership award in 2020. Jessica the Speech Pathology representative for the Critical Care Innovative Network at Ball Memorial Hospital.

Keep the Conversation Going

Thank you for listening to *The Missing Link for SLPs* podcast! **If you enjoyed the show, I'd love you to subscribe, rate it and leave a short review.** Also, please share an episode with a friend. Together we can raise awareness and help more SLPs find and connect those missing links to help them feel confident in their patient care every step of the way.

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Do you have a question you'd like answered on the show? Interested in sharing your experience as an SLP with our audience?
Send a message to Mattie@FreshSLP.com!

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The Missing Link for SLPs Podcast Show Notes

Mattie Murrey

We are going to be talking today with an intensive care speech-language pathologist, Jessica Durkovich. She has an exciting stage — a very small window, a very small specialty — where she works with intubated patients. She works with them while they're intubated and [is involved in] what happens after they're extubated. And she has some neat stories where she's talking with physicians about a bundle and some neat things like that — the A-F bundle. So, I'm excited you are with us today. And we are going to get started.

Mattie Murrey

Hello, and welcome to The Missing Link for SLPs podcast. I am so glad you are here. Today's episode is part of the Medical SLP series, where we talk to some amazing speech paths who work in a variety of medical settings, all the way from intensive care through to home care, and everything else in between and beyond. You're going to hear some incredible medical SLP stories and lots of advice from these passionate medical SLPs.

Mattie Murrey

So hi, Jessica. Welcome to this episode of The Missing Link for SLPs podcast. I'm happy you are here.

Jessica Durkovich

Good morning. Thank you for having me. I'm so excited to share.

Mattie Murrey

Now, in the preview, I said you are an intensive care ICU speech pathologist. And so, there are going to be a lot of listeners who are like, "My gosh, that's what I want to do. That's so exciting." Can you tell us first your story of why you became a speech pathologist?

Jessica Durkovich

I can! I It goes back to high school. I was a senior in high school, and our school allowed students to do a half-day internship if we had enough credits. And I actually thought I wanted to be a lawyer, like my dad, or a physical therapist. So, for my internship for the fall, I job-shadowed a physical therapist. And during that time, I got to spend time with the pediatric speech pathologists that worked on feeding. And I loved it. It wasn't something that I even knew existed. So, I did not do my spring semester as a lawyer. I decided that I wanted to do speech pathology and then went to school for it. I never changed my major during college. I just knew head-on that's what I wanted to do. My first career — my CFY — was actually in pediatric private practice. And then, after my CFY, I went into the hospital. I was pretty certain, even in grad school, that I wanted to be in the medical setting. And [I] got the job and never really looked back from the medical setting.

Mattie Murrey

So, your clinical fellow was in a pediatric outpatient private practice?

Jessica Durkovich

Yes.

Mattie Murrey

Working with Artic, or was it more of a medical outpatient?

Jessica Durkovich

It was not medical at all, really. We moved around a lot for my husband's job, and we had moved to a big city. And I knew no one. I didn't really even know the area, and really took a job that was available to get my CFY. And it was an outpatient clinic working on everything: language, artic, etc. I was contracted to a school that was a charter school for kids with autism. Then, when that year was over, I started looking for a hospital setting because I knew that's what I wanted. And the University of Pittsburgh Medical Center had a position posted. And I applied for it, and have been in the medical field since then. We've moved around a lot for my husband's job, but I've always been in a hospital setting.

Mattie Murrey

So, what did you do to prepare yourself for moving from your private practice into the medical setting? Did you take any courses?

Jessica Durkovich

I did continuing education [courses]. I had done an externship — my medical externship — at a hospital in Indianapolis. So, I felt prepared. I took courses during my CFY that were still medical-based. And I advocated for myself. I applied for a position that was actually a CFY position. They asked me why I should get that job even though I was done with my CFY. Also, one of the questions they asked at the interview was, what was my trach experience, and I didn't have any. And I was very honest, and said, "I haven't learned about that area yet. I haven't had hands-on experience, but I want the opportunity to learn." And they told me later that they appreciated my honesty. And honestly, [in] that job, I feel like I learned a tremendous amount. The therapists there were excellent, and I had great mentors and went from there.

Mattie Murrey

So, you stepped into a general medical SLP setting.

Jessica Durkovich

Correct.

Mattie Murrey

So, you and I know what that is. Can you explain to those listening what a general medical SLP does?

Jessica Durkovich

A general medical SLP does a little bit of everything. And for probably 10 years of my career, that's what I did. I did not step into this role in the ICU until about three-and-a-half years ago. So, [for] 10 or more years of my career, I was what would be considered a general medical SLP. And that involved stroke floors, stroke units. We had a cancer unit. The University of Pittsburgh has a large head-neck unit. Liver transplants. A lot of dysphagia. And some language and some cognition. The day is very flexible. You have to be quick-thinking on your feet. And we do a lot of swallow studies and radiology. Some FEES in my history. We don't currently do that at the facility that I'm at. It's a fast-paced and a busy environment. I love the ever changing [nature] of the medical setting.

Mattie Murrey

Especially the bigger medical settings.

Jessica Durkovich

Yes. A lot of it is medical chart reviews, bedside swallows, bedside swallow evaluations, [and] making referrals for if someone needs an instrumental exam. And then, like I mentioned, language evaluations, cognitive evaluations, referring patients for the next level of care — whether that would be acute rehab or a skilled nursing facility or home. And what services might a patient need once they transition home?

Mattie Murrey

So, you're in a bigger medical setting, a bigger city. So, you're describing the life of a medical SLP in a big, big medical Center. How many other speech pathologists are on staff with you?

Jessica Durkovich

So, currently, I'm in a medium-sized facility. We have probably seven speech pathologists, ranging from full-time to part time. I am actually a part-time speech pathologist. I cover the ICU Monday through Wednesday, and then, there are two other SLPs that rotate through on a three-month basis to cover Thursday and Friday.

Mattie Murrey

Wow, interesting pattern.

Jessica Durkovich

Yes.

Mattie Murrey

Neat. So, specifically honing in now on the intensive care work that you do, when does your day start? How do you start today? How do you get your patient list? How do you determine who to see? How much autonomy do you have?

Jessica Durkovich

Okay. I start my day around 8 o'clock. And the day starts initially in the speech office. As a team, we go through our day and kind of go over staffing. What does everyone's day look like? Who might need help? What swallow studies are on? I do help cover swallow studies for outpatient or the general medical floors if needed — if our staff ratio doesn't help cover that. Then, around 8:30 or 8:40, I round with our physical therapists and occupational therapists that cover the ICU and then our cardiac ICU. We have 36 beds total: 18 on our general ICU, 18 on recurrent ICU. One speech pathologist — myself — covers both sides in a general day. Now, there are days that you get crazy. Yesterday was one of those days that I needed to call in some help. So, generally though, it's enough for one therapist. And it's a pretty full, busy day. So, we round in the morning with PT, OT, and speech. We go through the patient list and kind of discuss their needs. Our physical therapists get ordered on our critical care order set right off the bat. They can then order occupational therapy. And we really have a conversation with the PT and OT [about] who has communication needs [and] who has cognitive needs. And then, we'll all talk about how we get in for swallowing.

So, we have worked very closely with our medical staff to get placed on our hospital's policy for the patient. We get in to see patients immediately — when they're intubated, as soon as they start waking them up off of sedation. We are consulted for communication. And our end can put in an order for speech to come in for communication. So, with that morning rounding, our PT and OT are kind of flagging, "Hey, this patient did a spontaneous awakening trial on the vent yesterday, which means that they're turning off all sedation while they're on the ventilator. And we think they're appropriate for speech therapy to come in and start working on communication." After we round, we go down to the floors and we start seeing people. Coordinating with the nurses. Coordinating with PT and OT. There are lots of interdisciplinary coordination and care. We start seeing people again, as soon as they are tolerating an SAT on the ventilator. SAT is a spontaneous awakening trial. They turn off all the sedating medications. We start seeing them when they're on the ventilator for communication and follow them through their stay. Once they're excavated, we, again, work with our physicians and have a policy in place that anyone intubated greater than 48 hours has a swallow evaluation. So, we evaluate their swallowing. And then, our standard work is that anyone intubated, again, more than 48 hours, will also have a cognitive evaluation. That's kind of the gist of how we get our orders and get our day rolling.

Mattie Murrey

It's very impressive. You've done a lot of back work on that.

Jessica Durkovich

We have. Yes. It's been a lot of building trust with our physicians and proving that we can be there. We try to get in within two to four hours once someone's extubated on swallowing. It's taken a lot of work to establish the trust that we will see their patients.

Mattie Murrey

What is it like when you first walk into a room with an intubated patient? Can you lay [out] that scenario for us?

Jessica Durkovich

Yes. So, pre-COVID, most often — or a lot of times, not always — we'd have family available. So, introduce yourself to the family. We look at, immediately, how alert is the patient? Are they visually tracking you around the room? That's the very first thing I'm looking at. Do they respond to their name? Do they turn their head? Then I start to look at their hands. How puffy and swollen are their hands? If we have done great with their sedation and they haven't been as sedated, we have patients that can move their hands great for pointing, writing, [and] using technology. If it's someone that's had to be on more medication, sometimes their hands are swollen up like balloons. So, I'm looking quickly at their hands to make an assessment on how I might be able to help that patient communicate. From there, I look at, can they answer yes/no questions with head nods [and] head shakes? Can they follow one-step commands? Can they point? If their hands look okay, then we look at writing. Can they hold a pen? Can they write on a whiteboard? Sometimes, I'm getting creative and using Coban to make pencils bigger, so that their grasp doesn't have to be so fine.

Mattie Murrey

Coban is the stretchy material.

Jessica Durkovich

Yes, Coban is the stretchy material that they use to wrap. We get creative. I've had my OT craft up pointers for me, for patients that maybe don't have good dexterity, so that they can point to a communication board. Because we are present in the ICU and have established a good relationship with our nurses... I had, last week, a nurse make a flipbook for a patient on her own. We also will occasionally use technology. I find, though, that a lot of our patients are too weak for the fine motor [skills] that technology entails. So usually, the best that we get is writing, a lot of times with some type of adaptation. So, we do the whole gamut. I have a girl right now that's just using yes/no on a board. It takes a lot of problem-solving and creativity to figure out how these patients can communicate.

Mattie Murrey

Is it scary walking into an ICU room?

Jessica Durkovich

I would say yes when I was a new grad. Absolutely. I can remember being a student in an ICU room with a trach patient, gowns head to toe and feeling hot and overwhelmed. Yes, it's scary as a new grad. Now, it's my day in and day out. It's not as rewarding. It's fun. It's hard,

emotionally, and sometimes physically. But I've gotten used to it. So, yes, initially, it is scary and it's hard. But if it's where you want to be and where your heart is, you can overcome that.

Mattie Murrey

When you walk into an ICU room, there's so much to take in.

Jessica Durkovich

Absolutely.

Mattie Murrey

So much to take in.

Jessica Durkovich

Absolutely. So, that is also some of my first... Before I touch the patient, I'm looking at their vitals, their heart rate, their respiratory rate, [and] how much oxygen are they on? If they're on a ventilator, what are their settings? Are they doing a breathing trial? Are they on heat of high flow? We are seeing more heat of high flow than ever before with the COVID pandemic. So, that's the nasal cannula that goes into the nose. I'm not generally seeing patients when they're on BiPap. We could see those patients for communication. However, generally, those patients are so tenuous that it's not the right time. So, taking in the whole... if it's a patient that's intubated, looking at what drips are they on? We will see people when they are sedated if they're waking up. So, I am documenting: Are they on Propofol? Are they on Fentanyl? We use Precedex. Looking at their IV poles, reading their drips. So, there is a lot to take in when you first walk into the room. Initially, it's observation. There's a lot of observation going on before even diving in to see the patient.

Mattie Murrey

But it's neat to hear that you can start in a general medical SLP position and move into something like that and feel competent. So, when you walk in the room and you see everything, you know how to walk forward in baby steps. Well, first, I'm going to check this. Then I'm going to check this. And then I'm going to note this and document this. So, it's your ability to walk in a room and problem-solve and critically think your way through an evaluation of a patient or treatment of a patient. It is very important.

Jessica Durkovich

And it has been a learning curve. So, this all got started... Our hospital ICU does the A-F Bundle, which is the ICU Liberation. I have a resource for that. And it's research supported that patients who do this bundle have better outcomes. They have shorter ICU stays. They are on the ventilator shorter, and they overall have better outcomes. We have an OT that really championed this and really championed therapy being an ICU. And we tend to have an approach that's more... Instead of being reactive, we're proactive. We're getting in there to try to prevent ICU-acquired weakness. We have found that getting in and working on communication early can help reduce our delirium rates, which then, delirium is directly

associated with long-term cognitive deficits. And then, also, [by] getting in on those swallow evaluations early, we are identifying risk for aspiration proactively instead of patients being excavated, started on a regular diet, and then failing. When our OT first approached me about doing this, it was scary. And she would throw out these medications and say that she's talking to the physicians about turning down medications or asking the nurses, and I thought, "I can't do that. That's not my scope of practice." But with our physicians' help, and our nurses and our ICU rehab team, my learning curve has been huge. And we work together as a team. I'm not the only one asking about these medications, or the only one looking at these things. And I think working as a team is what's really the most important and how you learn. I've learned so much from our interdisciplinary team. I would never have been able to do this as a lone speech pathologist.

Mattie Murrey

Well, there's some good words of advice right there: reach out to the team and [recognize] the strength of others. What is it like when you extubate a patient?

Jessica Durkovich

Okay. Once a patient is extubated, as I mentioned earlier, we generally wait two to four hours based on some of the research out there that says we don't need to wait 24 hours. And that was an older practice. I've worked that way previously. However, we found that with waiting 24 hours, sometimes physicians would just start patients on a diet. So, once the patient is extubated, our nurses know. They hold off. They don't give the patient anything, and they ask for the physician to put in the order for a dysphagia evaluation. We go in and we assess initially. The first thing I'm looking at is their level of alertness. Then, what is their voice like? Especially getting in that early, sometimes patients just aren't ready. And we definitely find that. But some patients amaze us. We just had a gentleman with COVID that did beautifully on his A-F bundle. [He] was very minimally sedated. His voice and his cognition were great right after extubation. He was able to start on a diet. We look at voice. We look at oral motor — so, how well are they moving their mouth, tongue, [and] lips? Then, I slowly start with... A lot of times, I start with oral care. [For] our nursing staff, the protocol is oral care every two hours. We all know in the medical setting, though, that could be better. So, there are times where my first step is just cleaning out their mouth — getting their mouth cleaned out, and then we'll try some ice chips. And I really go from there based on the patient and how well they tolerate.

It's a general clinical swallow eval that you would do on any other floor with the added [responsibilities of] looking at respiratory rate [and] looking at oxygen. We have found that [with] patients with COVID, you really, really have to watch oxygen saturations and respiratory rate with these patients. We look at, how well can they feed themselves? Some of these patients have ICU-acquired weakness and they can't get their hands to their mouth. So, they may or may need a softer-food diet or their food cut up just because feeding is a challenge. What I do find with these patients is a lot of them get better in that 24- to 48-hour window. So, we may just start with ice chips for overnight and come in, and they might be doing better and able to be up for a diet. Others, we're recommending for an instrumental exam. So, we're taking them to

radiology. It really is so patient-specific, and there are a lot of factors that play into diet recommendations. But once they're extubated, the clinical swallow evaluation looks very similar to the general medical floors with the close monitoring of respiratory status.

Mattie Murrey

Can you share with us a story of a patient that you will always remember, or [where] you're like, "This is why I do what I do"?

Jessica Durkovich

Absolutely. She actually just came back up this past week. In our college town — and I feel like it's okay to share this, it's been in the news — a young girl had a cardiac arrest in the parking lot. No one really knows why. But she had a cardiac arrest. She was on a ventilator. She also had a small stroke. So, when she was intubated, we were working on communication, with pointing initially. She was eventually able to do writing. And at one point, we even brought her a laptop so she could type. She then was extubated. And that 20-something had a pretty horrible swallow. No one likes to see a 20 year old on thickened liquids. She actually was NPO initially, thinking back on it. She had a feeding tube. Because of her cardiac arrest, she had a mild anoxic brain injury as well. We worked very hard on her swallowing. And she was... Was she a PhD student or a Master student? She was an advanced-degree student. Smart girl. So, we also worked hard on cognition. This was pre-COVID. So, we were able to eventually... In the ICU, we're doing aggressive therapy. We were able to take her out of her room, do some functional tasks with navigating the hospital and following multiple set directions, complex commands. She eventually left our facility, went to an acute rehab, and a year later, she graduated and has done extremely well. She had a 2% survival rate, and she is now working and healthy. [She's] on a regular diet. She was a true success.

Mattie Murrey

Excellent. Thank you for sharing that. What are some of the challenges working in the intensive care unit as an SLP?

Jessica Durkovich

With a year of COVID, it has been extremely emotional. It's been hard to see patients in isolation who aren't doing well and are scared. And sometimes, we're the only contact they have — and the nurses and the other therapists. But when you think a 30-minute visit might be their face to face — even though it's masked and face shields — or we may be their only physical contact for the day, it's been hard. It's been the hardest year of my career for sure. It's been emotional. We have lost patients.

Mattie Murrey

Me too.

Jessica Durkovich

Yes. The attachment that we've gotten to these patients has been nothing that I've ever experienced. And it's still going on. It's not over. We have a gentleman right now that might not make it, and before he was intubated, he was telling us he was fine. He's cognitively fine. I think that's what's been so hard about these patients is that they're with it. And minus their respiratory status, they're doing fine. And then they need to be intubated. And getting some of these patients off the ventilator has been so challenging. It's just been hard.

Mattie Murrey

I would agree with that. My daughter-in-law is an ICU nurse, and the listeners don't know this, but you do. I'm up visiting my kids. And we were talking last night — and my son is a nurse — and we just love talking about medical stories. And she has been a nurse for two years. And so, she was saying, "Yeah, I really understand now what a speech pathologist does." And she was sharing with me a story of a patient who was cognitively with it and talking and everything. And she had a sweetheart. She was in her mid-60s, and she'd been married for quite some years. And she and her husband were just in love with each other. And they were at the point where they needed to intubate her. And so, she helped her with that phone call before they intubated her. And she got to tell her husband how much she loved him. And they talked about the kids and such. And then she was intubated. And then she began to not do so well. It was a speech pathologist who came in and — this just gives me goosebumps — opened up that communication for her so she could write. And she did end up passing. But because of that speech pathologist and that whiteboard, she was able to say her final words and the family was able to read them.

Jessica Durkovich

I think the pandemic will hopefully change some of the trajectory of our field. I, for two or three years pre-pandemic, have been advocating for this position and really getting integrated into the ICU. And my facility accepted us. But man, there's not a lot of resources out there for a critical care speech pathologist. And a lot of it, I was being creative, and honestly at times, winging it. Not in the realm of swallowing because I feel like our field is there for swallowing. But for communication for these patients, there isn't a lot of continuing education. And there hasn't been a lot of information out there about the long-term cognitive deficits that come with a critical care stay. There are research articles that say that these exist, but there hasn't been a lot of information for what we do about it. So, working with our physicians and working with our team, we've really developed what we think... COVID has made it complicated, but our OT and myself have been trying to collect data to show what early intervention for communication and cognition does in an ICU. And we've had decent outcomes. There's research that shows that, one year after a critical care stay, patients have mild cognitive deficits, which is a [type of] dementia. And we are finding that a lot of patients immediately after extubation score an average 17-18 on the MoCA, which is moderate cognitive deficits.

Mattie Murrey

Out of 30. 17-18 out of 30.

Jessica Durkovich

Out of 30. Yes, you're right. Thank you. So, our hope is that, with getting in and doing earlier intervention, helping with communication, that we're preventing some of those deficits. And with the pandemic, it's been in the media even: how important communication is with these patients — and that patients that have brain fog [or] have memory loss after COVID really aren't any different. It is related to COVID, but our patients, or just respiratory failure or COPD exacerbation patients, have had these needs for years, and we haven't been addressing them. And I think it's really important that, as a field, we start addressing these things, and [that] we're helping patients with communication because it's important. Even pre-COVID, it was important.

Mattie Murrey

What is one of the most rewarding things you find about being a speech pathologist?

Jessica Durkovich

For a huge part of my career, I loved swallowing. Getting into the ICU, though, and working on communication has just lit a fire in me. Putting a Passy Muir valve on someone hearing their voice for the first time, it makes me emotional. I almost always cry because of the look on their faces when they hear their own voice. Giving someone a voice is so important for them to be able to tell their wants and needs, even if that is writing. But hearing a patient's actual voice is just one of my favorite things to do. And then, also, I still love swallowing. That part hasn't gone away. Getting a patient who we've worked and worked and worked and worked on swallowing [with] down to a regular diet... My favorite thing is to take them to get a pop afterward. Almost everyone always wants a Diet Coke or a Pepsi or a Mountain Dew. And we will go to the coffee shop, and we will get a pop and celebrate when they get down to that regular diet. That is also still one of my favorite things, progressing someone from being NPO all the way through to getting them back to regular food. So, I love both aspects of it. I love communication, and I still love swallowing too.

Mattie Murrey

Well, that's one of the beauties of our career. And I'm much like you when I'm working with a voice patient or putting a Passy Muir valve in. [That is] one of the stories my daughter in law shared again last night, was watching a speech pathologist put a Passy Muir valve in. And the patient had her voice back after six weeks. So, in that moment, I'm like, "Oh, this is my favorite." And then I'll do a video swallow [and say], "Oh, this is my favorite." I love the engagement that we can have and my small ability to play a positive part in somebody's communication or eating.

Jessica Durkovich

My husband makes fun of me because I will... Any high school senior or upperclassmen, I will grab them and say, "Maybe you should be a speech pathologist. Have you ever considered this field?" And actually, even just this week, our little kindergarten neighbor, as she was telling me,

"Maybe I should write a note on my door to remind my kids to wear a mask to school," I said, "You know what? You would make a great speech pathologist and help people with their memory strategies!" So, I love our field. I love the flexibility of it. I can't get enough of the medical field. But I also really appreciate that, say someone wanted to leave the medical field and go to the schools, that's an option available. There's so much you can do with it. I am also a mom. And I have only worked part-time since I had my two kids, and it gives me a great work-life balance. And with the moves that we have done, I've never had a hard time finding a job in a hospital that allows me that part-time flexibility, where I can be home with my kids but also be at work. And when I'm at work, I can give 110% because I have that work-life balance.

Mattie Murrey

Great. Final words of advice?

Jessica Durkovich

Advocate for yourself. Advocate for our profession. We have a place at the table in the ICU. And it takes a lot of work. Get to know your physicians. Get to know the other team members in the ICU. And you can build a program that's successful in the ICU by working with the team. It cannot be done alone, but by working with a team, you can advocate for yourself and have a place in the ICU.

Mattie Murrey

Thank you.

Jessica Durkovich

You're welcome.

Mattie Murrey

So, you're going to give us some of those resources that we'll include in the show notes. You'll find them there.

Jessica Durkovich

Yes, I will. I will send you a list of resources that I find are beneficial.

Mattie Murrey

Okay, great. Well, thank you for your time today, Jessica.

Jessica Durkovich

Thank you.