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Caring for Children in Child Welfare Systems: A Trauma-Informed Model of Integrated Primary Care

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Children involved with the child welfare system have high rates of behavioral health concerns, chronic health conditions, and developmental disabilities. Further, as a result of the complicated relationships among the court system, child protective services, and caregivers (i.e., biological, kinship, and/or foster caregivers) and the high volume of health-, behavior-, and development-related services children in care need, the services they receive tend to be fragmented and problem driven. On top of these challenges, children involved with the child welfare system have been exposed to trauma, and often more than one form of trauma. Taken together, these factors point to the need for care that is trauma-informed and integrated whereby health care is provided by a multidisciplinary team working collaboratively. This article describes such a model, including information about its development, structure and organization, and programs. It concludes with a discussion of lessons learned and remaining challenges.

Clinical Impact Statement
Integrated primary care is considered the gold standard for children involved in the child welfare system, but little guidance has been provided in the literature on operationalization of clinical program development. This article describes our center's evolution from a medical clinic to a trauma-informed, integrated primary care center that includes research and policy programming.

Keywords: pediatric integrated care, collaborative care, trauma, foster care, child welfare, treatment

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Over the last few decades, the United States has seen a dramatic increase in behavioral health diagnoses, particularly anxiety and depression (Twenge et al., 2010). About 50% of chronic behavioral health conditions begin by age 14 (Knopf, Park, & Mulye, 2008), and 20% of children (ages 0 to 18) in the United States have experienced behavioral health problems (Merikangas et al., 2010). Also concerning is that only a quarter of children with behavioral health concerns have received treatment (American Academy of Child and Adolescent Psychiatry [AACAP] Committee, 2009; Merikangas et al., 2011). Often-cited reasons for lack of treatment include a shortage in behavioral health professionals, lack of awareness, and stigma (e.g., Findling & Stepanova, 2018; Merikangas et al., 2011). This situation comes with significant costs: in the United States, three of the leading illnesses associated with pediatric disease burden are psychiatric (depression, bipolar disorder, and schizophrenia), and psychiatric illness in children and adolescents is a key risk factor for completed suicide (Bourgeois et al., 2012).

Traditional medical and mental health care is often siloed and limits comprehensive understanding of a child's needs. A promising strategy for addressing obstacles to treatment is *integrated primary care,* in which medical and behavioral health care are coordinated. The American Academy of Pediatrics (AAP) and AACAP issued a joint position paper (AAP, 2009) detailing the multiple benefits of children receiving initial behavioral health screening, assessment, and evidence-based behavioral health treatments in the medical home.

Integrated care may be particularly beneficial for populations of children known to have higher rates of behavioral health and/or development concerns. Children involved with the child welfare system are such a population; they not only have high rates of behavioral health challenges but also have disproportionate rates of physical health concerns (see, e.g., Kortenkamp & Ehrle, 2002; Leslie et al., 2005; Simms, Dubowitz, & Szilagyi, 2000). Using data from the National Survey of Children's Health to compare parent-reported behavioral health-related outcomes of children placed in foster care to those not in care, Turney and Wildeman (2016) found that children who had experienced foster care were almost twice as likely to have a learning disability, 3 times as likely to have attention-deficit/hyperactivity disorder, 5 times as likely to have anxiety, 6 times as likely to have behavioral problems, and 7 times as likely to have depression. Further, children in foster care were in poorer behavioral and physical health compared to children in almost every other type of family situation, including children in families with economic disadvantages.

Contributing to the health and development challenges children involved with the child welfare system face are their experiences of trauma. The types and frequency of traumatic experiences that result in children being removed from their homes vary, but the most common reason for removal is neglect (62%; U.S. Department of Health & Human Services, 2018). Further, even when removing children from their homes is in their best interest, children can experience removal as traumatic. These traumatic experiences can affect a child's behavior, emotional development, and behavioral and physical health.

Another important factor to consider in caring for children involved with the child welfare system is the level of coordination required to provide timely and appropriate health care. Because of the complicated relationships among the court system, child welfare professionals, and biological, kinship, and/or foster caregivers, services tend to be fragmented and problem driven. A policy statement issued by the AAP (2005) highlighted the challenges child welfare professionals and foster parents experience in negotiating the complex health care system for children with significant health care needs, and research with foster parents conducted by Pasztor, Hollinger, Inkelas, and Halfon (2006) found that being able to locate providers willing to work with foster children with significant medical issues is made difficult by the complexity of the cases, low Medicaid reimbursement rates, and fear of having to testify in court.

Taken together, these factors point to the need for trauma-informed, integrated care for children involved with the child welfare system. Indeed, the AAP (2005) has described this population of children as one with special health care needs. The organization has developed practice standards for caring for this population of children in which they call for primary care that is comprehensive, continuous, and coordinated across behavioral health, child develop-

ment, medical specialists, and child welfare workers.

This article describes an effort to operationalize the AAP's guidelines. After providing a brief overview of the history and current composition of the Rees-Jones Center for Foster Care Excellence, the article details each of the Center's three programs. The article next focuses on lessons learned during the Center's brief history, and it concludes with outstanding challenges.

Center Overview

History and Organization

The Rees-Jones Center for Foster Care Excellence (the Center) began as an extension of the Referral and Evaluation of At-Risk Children Clinic at Children's Health in Dallas, TX, in recognition of the need for follow-up services for children and resources for child protective services (CPS) caseworkers and foster and kinship caregivers. After serving as a medical home for children involved with the child welfare system for several years, the hospital system received a large gift from a private foundation to advance its vision of achieving hope, health, and healing for children in care by establishing an innovative model partnering medical and behavioral health care providers, academia, child protective services, and early childhood specialists to promote evidence-based, meaningful, and sustainable improvements for children in the child welfare system. The model has been implemented in the Children's Medical Center Dallas and Plano.

The Center currently has 45 team members. In keeping with the Center's interdisciplinary vision, the leadership team includes the medical director, lead psychologist, program administrator, and advocacy and research director. The team meets biweekly to address administrative concerns, plan, and inform each other about relevant developments within their purview. Additional leadership and support comes from the Center's oversight committee, which includes key leadership from the hospital and its affiliated academic medical center. The committee helps with overcoming administrative hurdles, building connections within and outside the institutional walls, and ensuring accountability of Center operations.

To encourage engagement among Center staff and communication between sites, everyone participates in at least one of four workgroups (community development, research and quality improvement, clinical innovations, and patient and family education). Cochairs for each workgroup have been selected through an application process. The workgroups are charged with identifying needs within their topical area and developing initiatives to address those needs. For example, rounding with patients about their experiences at the clinics revealed that some of our new patients felt they lacked a full understanding of our visit types and what they should expect at these visits. The patient and family education workgroup worked with the hospital's marketing division to develop a handout describing each visit type (see online supplemental material). Another example stems from the clinical innovations workgroup's recognition that families undergoing adoption needed additional support through the process. They developed a preadoption packet and checklist for families to facilitate the transition. Each workgroup reports to the oversight committee three times per year.

Programs

Efforts undertaken to advance the Center's vision fall into three overarching programs: clinical, academic, and community. These programs were selected based on the gaps and challenges identified from experience providing health care for children involved with the child welfare system and feedback obtained through a community needs assessment. This section provides details regarding each program.

Clinical. The Center operates two clinics, one at the ambulatory center at the children's hospital's urban campus and one at its suburban campus. The clinics serve as an integrated health home, providing trauma-informed health care to children in foster and kinship care. In 2018, over 1,800 unique patients were served in approximately 7,000 visits. An interdisciplinary team consisting of behavioral health experts, primary care providers, and child protective services liaisons ensures that the physical and behavioral health needs of children in the child welfare system are addressed in a trauma-informed and timely manner.

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Care coordination is a particular challenge in providing care to children involved in the child welfare system. For example, obtaining health records can be difficult. Care coordinators in the Center assist with locating past medical records and immunization registry information, coordinate services with external service providers (i.e., home health nursing companies, physical/speech/occupational therapy companies, durable medical equipment providers, and insurer), and serve as a point of contact for caregivers facing barriers to obtaining needed services. The Center team also includes two CPS liaisons, who are employed by the Department of Family Protective Services (DFPS) but are embedded in the Center full time, one liaison at each clinic site. As employees of DFPS, our CPS liaisons have access to the state's child welfare database. They cull information from the database and create summaries in the medical record that include children's reason for removal, the number of times they have been removed from their homes and/or moved placements, and medical and behavioral health information (e.g., results from past psychological evaluations). They also contact patients' caseworkers to gain additional information or provide important health information as needed. Another strategy employed to increase care coordination is a weekly huddle held on each campus, during which providers discuss patient care needs with the team.

The Center's interdisciplinary team uses the information to inform the new patient visit. Based on guidelines from AAP and state legislation passed in 2017, the goal is for a child new to kinship or foster care to be seen by a medical provider within 3 business days of removal and to see children who have moved placement as soon as possible after transition. These initial visits are critical to assess overall health and safety of the child and provide timely connection to needed services. At this new patient visit, children receive a medical screening intended to provide a baseline of physical health, and initial caregiver concerns are addressed. Also at the first visit, a child receives a developmentally appropriate social emotional bag, which includes a book about managing emotions or preacademic skill development and a developmentally appropriate toy/activity.

This first visit is typically followed by an integrated visit 4–6 weeks later. Integrated care in the Center follows an on-site collaborative care model (Kolko & Perrin, 2014) where the medical and behavioral health providers work together to provide trauma-informed assessment and treatment planning and connect families to services and supports, either internally or in the community, as appropriate. Pediatricians and nurse practitioners work alongside psychologists and behavioral health therapists for children ages 3 and older, and early childhood specialists work with medical providers for visits with children under 3 years of age. These initial integrated visits are scheduled for 90-min blocks, with follow-up integrated visits scheduled for 60 min.

Visits with school-age children and adolescents occur in *pods,* spaces that consist of child-friendly rooms adjacent to a small room with large windows that allow caregivers to speak freely with providers while still being able to observe the child. Providers work together to review collateral information and assessment data and interview a caregiver about the child's current medical and behavioral health-related needs. Medical and behavioral health providers each meet with the child, usually separately for privacy of school-age and adolescent children. Infants and toddlers are usually in an examination room with their caregivers for the entirety of their visits, and both medical and early childhood specialists work together to cointerview the caregivers and observe the children. Both medical and behavioral health providers give recommendations to caregivers based on the needs of the children.

The Center employs measurement-based care. In the context of integrated visits, the Center uses traditional primary care assessments, such as the Ages and Stages Questionnaire (Squires & Bricker, 2009) and the Modified Checklist for Autism in Toddlers (Robins, et al., 1999). The Center also uses VitalSign[6] screening for adolescents. This includes assessing for depression, anxiety, and activity levels. Caregivers of children 3 + receive the Pediatric Symptom Checklist, a broad behavioral health screener. Scores on these measures, along with a thorough intake process, help determine treatment needs and supports from which a child and family may benefit. Scores over time also help determine treatment approaches or if the child may benefit from other treatment options. When children present with significant needs related

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to trauma, anxiety, or other related behavioral health needs, additional assessments are administered.

Early childhood specialists serve as pediatrician extenders, providing developmental education to caregivers. They typically serve children from birth to age 5, although most children transition to a behavioral health provider for their integrated visits at age 3. The early childhood specialists can also help administer assessments and provide feedback as needed.

In addition to participation in integrated visits, behavioral health providers consult with primary care providers during medical appointments as needed. For new patient visits in particular, behavioral health providers may be brought in to provide resources and strategies for the management of developmental or behavioral health needs. Behavioral health clinicians may also be brought into medical appointments to provide safety planning, assess for suicidality, and determine if a child needs to receive more intensive services.

Center clinics also offer traditional primary care and behavioral health services. Primary care services include well-child visits, sick visits, and management of chronic health conditions. The Center follows the AAP (2005) augmented periodicity schedule, which recommends that children involved with the child welfare system be seen more frequently because of their status as a population with special health care needs. The state of Texas mandates that children receive a well-child check within 30 days of coming into care, and our Center offers this service.

Behavioral health clinicians provide therapy and testing services to children ages 3 to 21 years of age. Behavioral health clinicians are trained in evidence-based treatments, such as trauma-focused cognitive behavior therapy, cognitive behavior therapy, Triple P primary care, parent-child interaction therapy, and play therapy treatments. Psychologists oversee psychological assessments. Behavioral health clinicians also administer the state-mandated Child and Adolescent Needs and Strengths assessment (Lyons, 2009) to all new patients aged 3 and older. Data from screeners, along with more traditional psychological assessments, are used to inform children's needs. Results are shared with the caregiver, child, and CPS caseworker.

Given the diverse and numerous health-related challenges of the patient population and the range of services provided at the clinics, staff developed a tracking algorithm to assist with evaluating patients' acuity levels and planned follow-up. This algorithm was created to determine which children should continue with integrated care and which children are either sufficiently stable from a behavioral health perspective or are well connected to services and supports in the community and, thus, only need traditional primary care services. For the latter, behavioral health clinicians are available on an as-needed basis to provide support to families or children. The algorithm is fluid, and children can transition between integrated and nonintegrated care depending on their assessment scores, caregiver report of child needs, clinical assessment, and connection to community resources.

Academic. The Center's academic program has two primary components: (a) educating future health care providers in providing care for children involved with the child welfare system, principles of trauma-informed care, and the benefits of integrated care for vulnerable child populations and (b) conducting research to advance policy and practice. The Center serves as a training site for graduate students in psychology and offers a hospital-based, APA-accredited postdoctoral fellowship program in psychology. The Center also serves as a training site for medical students and residents in pediatrics and psychiatry, nursing and advanced practice nursing students, early childhood development students, and master's in public health students. Topics covered in training sessions with students and residents include the impact of adverse childhood experiences and toxic stress on child health outcomes, the health care needs of children involved with the child welfare system, and behavioral health assessments and treatments. All trainees receive both clinical and didactic training in the Center and the larger hospital system. Students also have opportunities to shadow providers during visits and to participate in team meetings. Center experts also provide substantial training to a variety of professional audiences at local, state, and national levels.

Regarding research and quality improvement efforts, our Center has prioritized studies aimed at improving patient care and informing policy development. Research efforts undertaken by Center staff and students include topics such as

caregiver stress as it relates to the health conditions of the child in their care, an overview of the health status of patients the Center services, analysis of the relationship between traumatic exposure and health status, evaluating trauma-informed training approaches for learners, and measuring and promoting resilience in children involved in the child welfare system. A program evaluation plan is in development, in consultation with experts in the field.

Community

The Center model recognizes the important role communities and community institutions play in promoting the well-being of children and families. The development of this third pillar of the Center's model resulted from findings of a community needs assessment suggesting that the Center should prioritize working with agencies, organizations, and individuals in the community that also serve children involved in the child welfare system. A community development manager leads such initiatives, with a focus on CPS health care case conferences, engaging caregivers, community-based trainings, and general foster care awareness campaigns to engage the broader community in supporting children involved with the child welfare system.

Care conferences. Care conferences are recommended when a child's needs are not being met or when it may be helpful to share common information among all individuals involved in a child's care. Care conferences are requested when a child or family may be struggling, or when there is an upcoming transition, to make sure all providers are working together to share appropriate information. A child's caseworker and all professionals working with the child are invited to attend. Following the meeting, a plan and summary are sent to all attendees, along with a list of responsibilities for various providers regarding follow-up.

Caregiver engagement. Our Family Advisory Council (FAC) includes former and current foster parents, adoptive parents, and kinship caregivers and will soon include an adult who has aged out of foster care. The FAC serves as a sounding board for Center staff. They provide feedback on all the patient materials created by staff, give programming suggestions, provide feedback on advocacy efforts, and initiate programs. Programs developed by the FAC have included a book drive to help support the early childhood team's literacy program and a caregiver mentoring program aimed at helping new caregivers navigate foster and kinship caregivers supports and, more generally, helping to normalize the experience of being a foster or kinship caregiver.

Training. Training efforts seek to promote best practices, evidence-based approaches, and dissemination of information among foster parents, child placement agencies, CPS, court-appointed special advocates, and other interested advocates. A community needs assessment helped to identify gaps in available trainings. Additionally, the Center's community development manager actively seeks opportunities for staff to provide training to individuals and organizations with whom our patients and families come in contact, such as school personnel, court-appointed special advocate (CASA) volunteers, and CPS caseworkers.

Advocacy and awareness raising. The Center's advocacy and awareness-raising activities take many forms. At the state level, Center staff participate in a collaborative focused on child protection and one focused on mental health. In addition to working with like-minded partner organizations to advocate for policies and practices that promote the well-being of children involved in the child welfare system, Center staff engage in the legislative process by meeting directly with legislatures on topics and bills that directly impact our patient population, submitting written testimony to relevant committees, testifying during committee hearings, and composing policy briefs. For example, Center leadership and the hospital's government relations office advocated for a requirement based on the AAP's recommendation that children be seen by a medical provider within 72 hours of coming into care. Working with DFPS, Health and Human Services (HHSC), and the managed care organization that insures children in foster care on policy development and implementation is also a key component of the Center's advocacy efforts.

At the regional level, the Center founded and serves on the steering committee of a foster care consortium. The consortium consists of organizations and individuals committed to promoting the well-being of children in child welfare through communication, collaboration, and in-

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formation sharing; innovation; sharing and developing resources; and advocating for policies and laws consistent with the consortium's mission. The consortium seeks to increase awareness of local programs and services focused on foster care and to bring these programs and services together to learn and to advocate. A bill requiring that children be seen by a medical provider within 3 business days of coming into care was signed into law in 2017.

Lessons Learned

The Center has engaged in continuous program improvement by utilizing hospital and community resources. Several innovations and redesigns were aimed to meet patient, caregiver, and community needs. In general, lessons learned fall into five categories: ethical, financial, structural, research, and education and training.

Ethical

Implementing this highly collaborative model of care for a complex and vulnerable pediatric population has been rewarding, but it has not been without its challenges. Indeed, the model raises some ethical issues for providers. For instance, children in child welfare have limited confidentiality with so many people invested in their care. It is not uncommon for a child's medical and mental health records to be reviewed by attorneys and judges, caregivers, CPS, CPAs, CASAs, and clinicians. Additionally, in integrated visits, our behavioral health providers are not the primary mental health provider as most children involved with the child welfare system receive counseling or behavior skills services from a private clinician, whereas the primary care providers are the primary medical providers. The behavioral health team works closely with the family to empower them to be a part of the therapy process when a child's mental health symptoms appear to be increasing in intensity, to provide education to foster parents about evidence-based treatments, and to encourage them to work with their community-based mental health therapist to find treatments that can help the child's symptoms decrease. Another ethical dilemma encountered by our integrated care clinicians includes requests from CPS to complete affidavits for court for placement decisions. Our team will often provide a letter on a patient to whom they have provided care but does not typically provide placement affidavits because our team can only comment on the care the child has received in the Center.

Financial

The Center is fortunate to have received significant philanthropic support to enable the provision of the services it provides. For long-term sustainability and to enable more centers like this one, a key aim is to encourage reimbursement that is commensurate with the level of care provided. That requires recognizing that integrated visits take longer than a typical visit, include two providers in the room with the patient at the same time, and need more time for providers to offer education and support to caregivers. To date, Center staff have met with internal financial leadership, leadership of the managed care organization that provides insurance for children in care, and HHSC leaders to advocate for policies that ensure children involved with the child welfare system have access to the best health care possible by ensuring that funding structures are in place to reimburse such care.

Structural

Obstacles to communicating across systems make it difficult to provide efficient and effective care. Indeed, many children in the child welfare system interact with a variety of clinicians and other practitioners as a result of their numerous medical and behavioral health needs. Often, however, these individuals do not communicate with one another, which makes it impossible to ensure that the goals and recommendations for a child's care are aligned. Further, it makes providing care more difficult for the caregiver. Care conferences have helped to bridge communication, but gaps still exist. In situations where referrals to outside providers are not acted upon, a team member reaches out to the CPS caseworker to discuss strategies for ensuring that the child's needs are being met.

Another challenge relates to obtaining children's health histories. Texas has a secure web-based application, Health Passport, that allows medical consenters, health care providers, CPS

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caseworkers, and health plan staff to access stored health information pulled from claims data on children involved with the child welfare system. Because the application depends on providers to enter health data into the system—in effect, to double-document without compensation—the information provided offers an incomplete, and sometimes inaccurate, picture of a child's needs. Also, claims data notifies a provider of whether a particular lab was drawn or test administered but does not provide the results of the procedure. Because of concerns regarding access and accuracy of health information, although Health Passport is reviewed, Center nurses also obtain children's birth and medical records.

Another structural challenge relates to the disconnect between the makeup of many foster homes and the way in which the internal schedule and electronic documentation system is set up. Many foster families have multiple children in their home, who may or may not be related, and they often want to bring all the children at the same time for their visits. From the perspective of caregivers, being able to have all the children in one's care seen on the same day is time saving and potentially stress reducing. The Center, however, has longer appointment times and, thus, can only accommodate up to three siblings per morning or afternoon block for integrated visits. If a caregiver cancels a block of three patients, two clinicians' afternoons are open, leaving limited time to fill the slots with other patients. To maximize efficiency, Center team members worked with the quality and safety division to implement a quality improvement project, which improved slot utilization and visit flow. Further, the team has worked with the information systems division to maximize efficiency in encounter creation and management.

Education and Training

As the Center continues to evolve, the importance of ongoing trauma education and support has become apparent. Initial team member trauma training has focused on introducing the concept of trauma, its impact, and how to work with a patient who has experienced trauma. Working with children who have experienced the amount and types of trauma Center patients have can itself cause trauma. To address secondary traumatic stress and prevent burnout, Center leadership added self-care activities to all quarterly staff meetings. These activities have included guided imagery exercises, education on the components for enhancing clinician engagement and reducing trauma (CE-CERT) model of care (Miller & Sprang, 2017), mandala art, the importance of nutrition on physical and mental health, personality style in the workplace, and use of assessments that reflect on how people engage in self-care. Further, Center team members have created buddy systems to debrief on tough cases and a Trauma-Focused Cognitive Behavior Therapy (TF-CBT) consultation group, and staff are encouraged to take advantage of supports available through Children's Health's employee assistance and wellness plan.

Research

There are several challenges in conducting research in the area of child welfare. Because children involved in the child welfare system have protected status, demographic data such as maltreatment history and living situation is kept confidential by CPS. Thus, research efforts typically require making an official request to CPS and undergoing its review process in addition to the researcher's institutional review board's process. The CPS review process can take several months, and sometimes years, depending on the sensitivity of the data requested and the ease with which the requested information can be retrieved by CPS.

The Center, with the support of Children's Health's legal team, worked with DFPS in Texas to have language added to its information request requirements allowing hospitals to use their own data for research purposes. The following statement was added:

> DFPS approval or consent is not required for Institutional Review Board-approved research involving de-identified retrospective data of children currently or formerly in conservatorship if the de-identified data is obtained from health system or hospital records and consent would not be required for children not currently or formerly involved in DFPS conservatorship or services.

This language enables the Center to conduct and share research aimed at increasing understanding of the needs of children in care.

In addition to challenges related to retrospective reviews or obtaining sociodemographic

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data on children in care, enrolling children involved in the child welfare system in a prospective research study requires several additional steps and protections. Enrolling a child in a study typically requires the consent of the legal guardian. For children in care, determining who serves as the legal guardian is not always straightforward. Further, approval usually must be obtained from multiple individuals (e.g., caseworker, biological parent, caregiver). Finally, given the transient nature of children in care, conducting longitudinal research can be both difficult and costly.

Conclusion

This article sought to describe an innovative model for providing integrated care to children involved in the child welfare system. In addition to detailing the Center's structure and design, the article included a description of some of the challenges faced and how they have been addressed. There are still, however, some outstanding challenges to resolve, most of which relate to the sustainability of the model. The model still needs to be formally evaluated, and the creation of an evaluation plan is almost complete. The lack of research in this area has made designing an evaluation difficult, along with the inherent challenges of conducting any type of research with children in care (as detailed in the Research section).

In addition to the need to show model outcomes, the Center continues to advocate for reimbursement rates commensurate with the quality of care provided. In that regard, the leadership team has been working with statewide professional and child advocacy organizations and the American Psychological Association to discern strategies for promoting administrative and legislative changes to enable flexibility and encourage innovation in funding mechanisms and strategies. Efforts have also included examining strategies employed in other states, along with internal reviews to maximize reimbursement potential.

In sum, integrated primary care is held up as the gold standard for children involved in the child welfare system, but little guidance has been provided on how to operationalize this recommendation. This article contributes to the literature by addressing this gap. The next step is to address the lack of outcome data on integrated care, which will be used to inform policy and reimbursement models.

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