

Kinship Care and Foster Care: A Comparison of Out-of-Home Placement From the Perspective of Child Abuse Experts in North Carolina

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BACKGROUND Children may be placed in either kinship or foster care, forms of out-of-home placement (OHP), if maltreatment is suspected. The American Academy of Pediatrics has identified them as children with special health needs requiring elevated care. While North Carolina has increased support for foster care, it is unclear whether similar support exists for kinship care. Child abuse medical providers (CAMPs) were interviewed regarding their understanding and assessment of the state of the kinship care system in North Carolina, and how it can be improved.

METHODS CAMPs were individually interviewed using a semi-structured, open-ended question guide to assess their perspectives on kinship versus foster care in North Carolina. Data were coded, and the analysis was conducted in an inductive manner, allowing themes and then recommendations to emerge from interviews.

RESULTS The following three themes were identified: 1) providers have a foundational understanding of the kinship care system, marked by knowledge gaps; 2) children in kinship care and foster care have equivalent, elevated health needs, but children in kinship care do not receive the same level of care; 3) individual and structural changes have to be made to the interprofessional teams working within the OHP system.

LIMITATIONS The study sample was small, including eight CAMPs who had relatively homogenous demographic characteristics. CAMPs typically see the worst cases of maltreatment, which may bias responses. Additionally, the majority of children in kinship care are unknown to CAMPs and may not be fully represented in responses.

CONCLUSION CAMPs' responses were summarized into a set of recommendations targeting four different components of the OHP team: the general interprofessional team, policymakers and state leaders, medical providers, and social workers.

North Carolina has identified child welfare and safety as key priorities. In 2014, North Carolina funded Fostering Health NC, a comprehensive program that facilitates trauma-informed care for children in foster care through collaboration between medical providers, the Department of Social Services (DSS), and Community Care of North Carolina networks [1]. Given its success, the North Carolina legislature extended funding for the program in 2018 and passed Rylan's Law, which requires restructuring programs to promote well-being for children in foster care [2, 3]. The American Academy of Pediatrics (AAP) has also issued policy guidelines for children in foster care, with the qualification that they are "relevant to all children who come into contact with the child welfare system" [4]. These are essential steps to improve child welfare.

DSS utilizes kinship and foster care as out-of-home placement (OHP) to ensure a child's safety if maltreatment in the home is suspected [5]. Traditional thinking is that placing a child with a known caregiver is preferable to placing them with a stranger, although national research is inconclusive [6]. Federal and state regulations favor kinship care, as reflected in North Carolina's 2016 OHP statistics: 10,425 children in foster care and 84,000 in kinship care [7-9]. Any child in OHP faces considerable obstacles and is designated as a "child with special health care needs" (CSHCN) by the AAP [4, 6, 10]. Regardless of placement

type, it is estimated that 30%-80% of children enter OHP with at least one medical problem, up to 80% enter with significant mental health issues, and 40% have significant oral health issues [4]. Additionally, exposure to toxic stress, such as the trauma precipitating entry into the OHP system, disrupts brain architecture causing permanent changes that may translate into chronic disease [11].

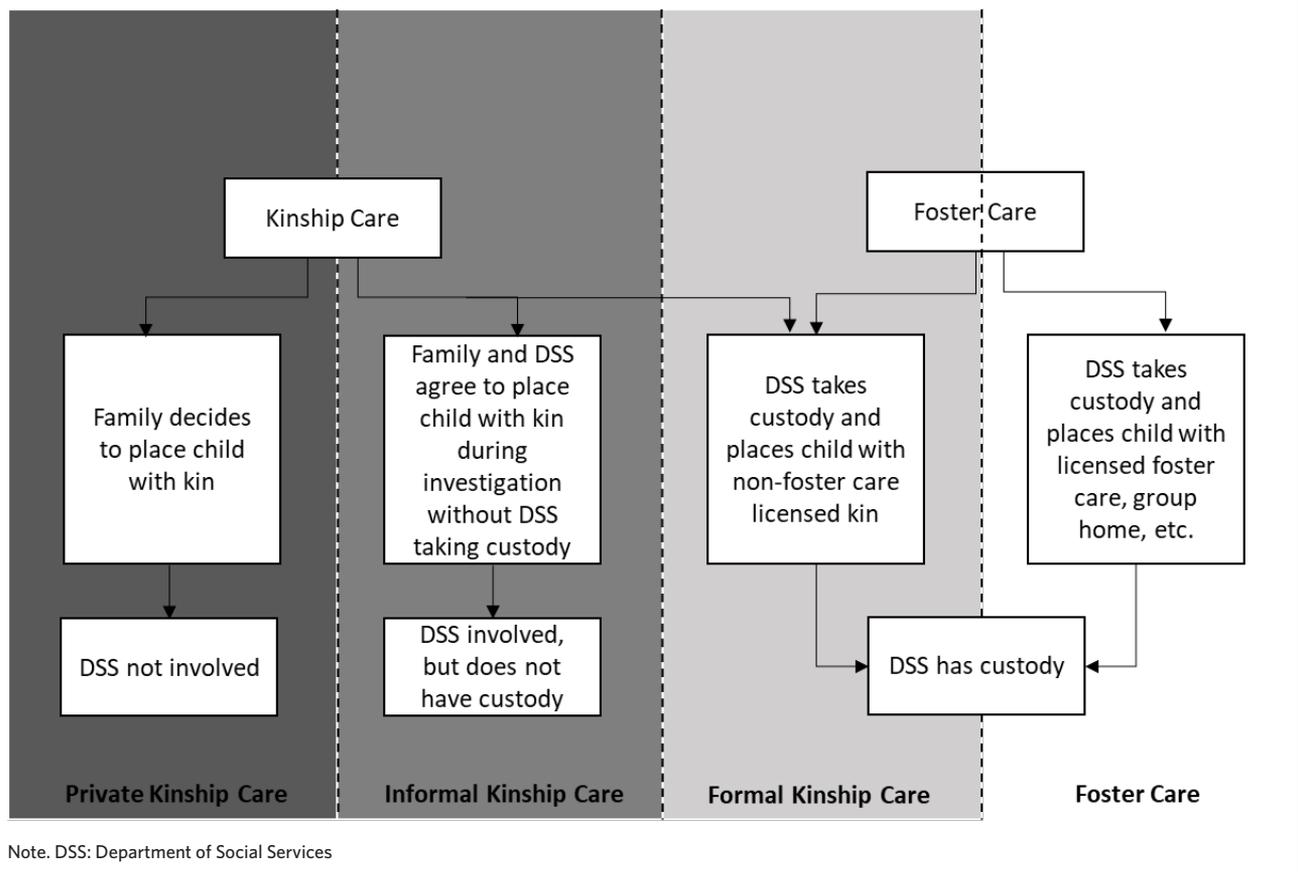
Despite the apparent preference for kinship care, there appears to be a discrepancy in support [12-14]. Our objective was to assess the North Carolina kinship care system from the perspective of on-the-ground OHP professionals, child abuse medical providers (CAMPs), and gather their opinions on how stakeholders can work together to ensure the well-being of children in kinship care. While CAMPs are not the only providers to see children in OHP, they were chosen due to their trauma-specific training in health promotion and disease prevention of children, routine access to children through medical homes, and exposure to children in formal and informal placements. Then, we summarized the CAMPs'

Electronically published November 4, 2019.

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N C Med J. 2019;80(6):325-331. ©2019 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2019/80601

FIGURE 1.
OHP Based on DSS Involvement and Caregiver Type



responses into recommendations specifically addressing the needs of children in kinship care in North Carolina.

Methodology

Definitions

Kinship care can be divided into three categories: private, informal, and formal (see Figure 1) [6]. Formal kinship refers to a legal arrangement in which a child welfare agency has custody of a child, but the child lives with kin [6]. Informal kinship care is when a child welfare agency assists in the placement of a child with kin, but the agency does not obtain custody [6]. Private kinship care is a voluntary arrangement between the birth parents and kin without involvement of a child welfare agency [6]. Little is known about private kinship care, but it is thought to be the most prevalent form of OHP [15].

Sampling

Participants were CAMPs, either pediatricians or nurse practitioners (NPs), practicing in North Carolina with a minimum of five years of experience. Physicians completed pediatric residency and fellowship to become board certified in the child abuse pediatric subspecialty. NPs completed masters or doctoral level training and focused training in child maltreatment. CAMPs conduct medical evaluations of

children who may have experienced maltreatment and they frequently interface with other OHP professionals.

Participants were recruited in 2016 using key informant sampling of the Committee on Child Abuse and Neglect (CCAN) within the North Carolina Pediatric Society. Geographic diversity was also considered in participant selection. CAMPs from the research group's home medical institution were ineligible. Eight interviews were completed from a cohort of 14 eligible CAMPs before data redundancy was achieved and recruitment was terminated.

CAMPs gave oral consent prior to being interviewed. Participants were assured confidentiality. The institutional review board at the home institution approved the study.

Data Collection

We developed an open-ended, semi-structured interview. This was done after a literature review of OHP and discussion among the study team, which included a student enrolled in medical and public health programs, a qualitative research expert, a child abuse fellow, and a child abuse attending physician. The question guide was designed to ensure each interviewee discussed the same topics, while allowing elaboration on issues most relevant to their experiences. The open-ended nature of the questions allowed the participants to answer the questions in their own words

without bias from the research team. One trained team member conducted all interviews in English, minimizing variation in the interview process.

Each interview took approximately 60 minutes and was conducted in person or over the phone. All interviews were audio-recorded and transcribed verbatim. The study team periodically reviewed the question guide as interviews progressed. Additional or clarifying questions were added as needed to elucidate the conversations.

Analysis

Each member of the team independently reviewed two of the same transcripts and developed a list of applicable codes. The team reconvened to generate the initial codebook and two team members acted as coders. Each read and analyzed all the transcripts, meeting periodically to discuss discrepancies in coding until consensus was reached. The codebook was modified by the research team in an iterative fashion. The codes were grouped thematically through inductive qualitative analysis to capture emerging concepts. Transcripts were then reviewed again using thematic codes to organize recommendations made by CAMPs. All analysis took place in the qualitative software ATLAS.ti 7.5.10.

Results

Primary Findings

Three primary concepts emerged through inductive qualitative analysis: 1) while CAMPs have a basic understanding of North Carolina kinship care, knowledge gaps exist; 2) CAMPs recognize that children in kinship and foster care have similarly elevated health needs, but children in kinship care may not receive the same level of care, particularly for mental health; and 3) individual and structural changes have to be made to the interprofessional teams working within the OHP system. These are discussed fully in the following paragraphs. See Table 1 for CAMPs demographic characteristics.

Theme 1: CAMP knowledge base. Providers had a strong understanding of system basics, with most recognizing a kinship caregiver does not have to be a blood relative. CAMPs focused on aspects affecting a child's ability to receive appropriate medical care, like who can give consent. While several participants alluded to the fact that a child may not be in DSS custody during placement, only two explicitly discussed the different forms of kinship care. CAMPs, identified here by their interview numbers, also spoke of differential resources available based on the OHP type, as well as their concern that this may lead to disparities in care:

"Usually in the case of kinship, the limitation around that sort of arrangement is the lack of access to the same benefits [health care coverage, foster care board payments]. Oftentimes it's an out-of-pocket expense for families." (SD7)

CAMPs' breadth of knowledge varied, particularly regarding federal and state policies. Participants were con-

cerned that since OHP is a multidisciplinary system, these uncertainties could generate misunderstandings between different OHP professionals regarding appropriate care for a child in kinship care:

"People [medical providers] say, 'Don't call social services. They don't get anything done.' They [medical providers] don't have any idea of what the law says that they [social workers] have to do. What kind of cases they can and can't take." (SD6)

This frequently manifested in additional conversation regarding the need for education among all OHP professionals, but most critically medical providers and potentially social workers:

"You know the sad part is that you've kind of highlighted a lot of interesting deep dark holes that I really have not delved into myself. Now I'm going to have to find the answers to the questions." (SD1)

Theme 2: Equal need, unequal access. All CAMPs agreed that regardless of placement, any child removed from their home due to alleged maltreatment has experienced trauma. Participants saw the preference for kinship care as minimizing the chaos experienced by children:

"I think what we see happening in placements of all kinds is kids wind up having a new medical home, in addition to a new school, and a new house, and a new neighborhood. I think you start to break down one by one the kid's social bonds. I think there's some advantage to maintaining a child's other social structures." (SD5)

TABLE 1.
Characteristics of Child Abuse Medical Professionals

Demographic Characteristics (N = 8)	N
Experience (years)	
Mean +/- SD	18.4 +/- 10.2
Range	7 - 40
Gender	
Female	7
Male	1
Race	
White	8
Professional Characteristics (N = 8)	
Profession Type - no. (%)	
Physician	6
Nurse Practitioner	2
Dominant Care Type - no (%)	
Inpatient	2
Outpatient	2
Both equally	4
Dominant OHP Type Seen	
Foster Care	1
Kinship Care	3
Both equally	2
Unknown	2

However, others cautioned against assuming kinship caregivers have greater knowledge:

"I rather them be with the appropriate grandparent than the appropriate stranger. Having said that, we don't want to falsely assume that the grandparent knows everything... Sometimes, I worry that if they're not in foster care, it won't rise to the level of rigorous review." (SD3)

CAMPs were most concerned about the mental well-being of children in kinship care since kinship caregivers were perceived as having less access to resources than foster caregivers:

"I think if they're in the custody of DSS that opens accessibility to insurance and potentially additional pathways that makes it easier for them to get services. I think if they're not in the custody of DSS...that can make it difficult." (SD3)

"By not being licensed and going through the bare minimum of training, caregivers really have no earthly idea of what trauma looks like in a kid. You're going to be seeing some horrible behaviors... So if you're not formally trained to deal with that, you'll beat that child yourself. You will say, 'Come pick this kid up. Take him.' That kid will have another loss." (SD7)

While multiple CAMPs recognized that the legal recognition of foster care afforded more services, all CAMPs saw children in kinship care and foster care as having equal need deserving of equal resources:

"Something was bad enough that they were pulled from their biological parents so wherever they land, we need to be looking and making sure they're progressing." (SD4)

Theme 3: Maximizing multidisciplinary teams. Given this apparent discrepancy in care, all CAMPs were asked how they would improve OHP for kinship families. Suggestions for social workers included sharing with kinship caregivers already-available community resources on trauma-informed care, particularly those targeting foster caregivers:

"I've had some social workers talk to be me about cases where inappropriate discipline was being used for the age of the child. Instead of understanding time-out, they'd use spanking. Social workers can advocate for using more appropriate methods of discipline." (SD5)

The most common suggestion was to monitor children in kinship care as diligently as those in foster care. This was thought to be critical for social workers, as they have the most consistent contact with a child:

"Keep making sure that the child is being taken to their follow-up medical appointments... They [social workers] are the only ones that can really ensure it at that point because they're the ones with the regular follow-up with the child." (SD8)

Suggestions for medical professionals focused on increased education regarding OHP and maintaining strong relationships between OHP professionals:

"A social worker that respects the medical provider is much more likely to work really hard to carry out a plan and make sure things happen the way they're supposed to versus a situation where there's conflict or power differential." (SD1)

While CAMPs valued individual-level modifications, they saw system-level modifications as necessary for sustainable improvements. Multiple participants called for standardizing the care all children receive while going through the OHP process:

"The core issue is that they're abused, neglected, and dependent. Regardless of whether they're in a foster home, a licensed kinship placement, or an informal kinship placement, the service array should be the same. The protocol for assessing needs and following up for safety should be [the] same. There shouldn't be a subset of kids who have less services because of some DSS designation. To me, that's the insane part." (SD7)

Discussion

Our study interviewed professionals well versed in OHP to better understand kinship care in North Carolina. Interviews demonstrated that even CAMPs had only a basic understanding of the subject, reflecting complexity seen in previous research. However, interviewees also had insight on how to advance care for children in kinship care. Based on key themes from the interviews, the following recommendations are offered for consideration by OHP stakeholders (see Table 2).

Recommendations for Interprofessional Teams

During interviews, CAMPs were adamant that the success of children in kinship care is contingent on the interaction of diverse professionals. In order to facilitate effective interactions, they suggested using a preexisting framework: the AAP OHP care guidelines (see Tables 3, 4) [4]. This framework applies listed service recommendations to all children who come into contact with the child welfare system. Therefore, training modules should be developed to ensure all OHP professionals are aware of the AAP guidelines, particularly the rationale behind the guidelines. These guidelines allow professionals to approach kinship care from an identical perspective, while providing them with a standardized method of initiating, evaluating, and advocating for a child's health. Additionally, Fostering Health NC has devoted substantial effort to devising recommendations under the principle that the well-being of children in foster care is dependent on a strategic partnership between three stakeholders: the primary care provider, county DSS, and care management [16]. While Fostering Health NC's guidelines are directed at foster care systems, CAMPs reinforced that the parallel needs

TABLE 2.
CAMP Recommendations for Improving the Well-being of Children in Kinship Care

Recommendations	Thematic Base
Interprofessional Teams	
1. Develop training modules for all OHP professionals regarding AAP recommendations for kinship and foster care, with a specific emphasis on rationale.	1
2. Develop or utilize existing local, county, and LME/MCO interprofessional teams to champion best practices for children in OHP locally as per Fostering Health NC guidelines.	2, 3
3. Support use of evidence-informed team-building practices, such as TEAMSTEPPS, to optimize team functionality.	3
Policymakers and State Leaders	
1. Clarify expectations for initial and 30-day medical evaluations, regardless of type of OHP, including when children in informal kinship care should be referred for medical evaluations.	1,2,3
2. Develop processes that ensure all children in OHP receive timely and appropriate mental health care.	3
3. Encourage child welfare agencies to actively support foster care training, access to resources, and/or licensing for all kinship caregivers.	2, 3
4. Develop state-level registry to track all children in formal and informal kinship placement (ie, children with DSS involvement) to accurately assess the scope of OHP and provide appropriate programming per Rylan's Law.	3
Medical Providers Caring for Children in OHP	
1. Develop training modules for medical providers on federal and state policies regarding kinship care, including various definitions and available resources.	1
2. Develop training modules for medical providers regarding the professional responsibilities of their social worker colleagues, including statutory responsibilities and scope of practice.	1
3. All medical providers should directly inquire about a child's living situation during each medical encounter.	3
4. Include a child's placement status, using appropriate terms and definitions, prominently in their electronic medical record.	3
5. Develop practice-specific patient registries for children in OHP to facilitate following the specialized periodicity schedule for children in OHP, ensuring appropriate care coordination among medical and community professionals.	2, 3
Social Workers	
1. Refer children for their initial and 30-day medical evaluations per AAP guidelines, regardless of type of OHP, including children placed in informal kinship care.	2
2. Develop and share focused training and resource packages for kinship caregivers to utilize during placement that include resources from nationally recognized sources, such as Fostering Health NC and the AAP.	3

of children in kinship care mean that they can be readily applied to kinship care systems [4]. Guidelines that can be used to champion best practices locally can be found on the Fostering Health NC website [17].

Recommendations for Policymakers and State Leaders

The AAP has clear care guidelines for children in OHP, but only 71% of North Carolina's foster children received their regular schedule of well visits, and CAMPs noted that this figure is unknown for kinship care as there is no formal registry to track families [18]. While the AAP is explicit in its recommendations, North Carolina policy only states that "the [child welfare] agency shall ensure that the child receives all needed evaluations, medical care and psychological treatment services needed through referral to other agencies and providers" [5]. Given the ambiguity of the statement and the acuity of the health needs of children in OHP, CAMPs recommended policymakers clarify expectations regarding standards of care for all children, with particular effort made to adhere to AAP recommendations. As North Carolina's child welfare system is state supervised and county administered, the most effective way to do so would be via written policies at the state level, specifically in the North Carolina DSS manual. CAMPs most frequently brought up the need for explicit policy for mental health services as 80% of children enter OHP with a significant mental

health issue and children in kinship care are half as likely to receive outpatient mental health evaluations [19, 20].

Additionally, CAMPs expressed concern that all foster caregivers must be formally licensed, but not all kinship caregivers. This distinction grants foster caregivers access to education, financial subsidies, and a variety of health supports meant to facilitate a child's well-being [12-14]. The DSS manual states that the agency shall support kinship caregiver training only "when necessary and appropriate [...]" so that they can provide care for the child" [5]. Yet, all OHP children have advanced needs posing equivalent responsibilities for caregivers [4]. Therefore, multiple CAMPs proposed that DSS standardize its support of licensing and/or training to all kinship caregivers so that they can appropriately care for these advanced needs. Examples include offering more flexible training schedules and providing childcare during such trainings. This can be done concurrently with a child's placement and should not delay a child placement in an appropriate home.

Recommendations for Medical Providers Caring for Children in OHP

Given the knowledge gaps brought up by CAMPs, it may be beneficial to develop state-level training modules for pediatricians that delineate federal and state policies regarding kinship care, including various definitions, avail-

able resources, and the professional responsibility of social worker peers. Not only can this directly impact practice, but it can facilitate efficient interprofessional interactions. For example, it may be more expedient for medical providers to place internal referrals to other specialists at their institution, instead of having a social worker make those appointments for a child.

As there is no formal kinship care database, all pediatric providers should directly inquire about a child's living arrangement at every medical encounter. It is common for a child to be taken to their pediatrician appointment by a relative if a biological parent is unavailable. Unless they ask, pediatricians will not know with whom and under which conditions the child is living. Pediatricians are uniquely poised in their access to children, with the potential to intervene regardless of a family's involvement with child welfare agencies [20]. Pediatric providers should also consider developing a clinic-based registry of their patients in OHP, similar to registries for patients with asthma or other chronic conditions. This may help improve the tracking of referrals and ensure compliance with the AAP recommendations for visit frequency.

Recommendations for Social Workers Caring for Children in OHP

Given the equivalent needs of all children in OHP, CAMPs suggested that social workers should refer all children in OHP to the appropriate care per AAP guidelines. The DSS manual states that "whether the home is licensed as a foster home, social workers shall have face-to-face contact with the kinship caregiver" [5]. However, it is unclear whether this translates into referral services for children for whom they are not legally responsible, like those in informal kinship care. This is a key service as toxic stress during early childhood disrupts brain architecture, causing permanent changes that may translate into higher levels of chronic disease like diabetes and unhealthy lifestyles marked by illicit drug use and low educational attainment [11]. Fortunately, childhood intervention can mitigate damage, but it requires prompt medical attention and the appropriate caregiver training [11].

TABLE 3.
Fundamental Principles of AAP OHP Standards of Care

Children in OHP should be seen early and have an enhanced health care schedule

- To assess for signs and symptoms of child abuse and neglect
- To assess for presence of acute and chronic illness
- To assess for signs of acute or severe mental health problems
- To monitor adjustment to OHP
- To ensure a child or teen has all necessary medical equipment and medications
- To support and educate parents (foster and birth) and kin

Source. Szilagyi M, Rosen D, Rubin D, Zlotnik, S. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics* 2015; 136(4): e1142-e1166.

TABLE 4.
AAP OHP Standards of Care

Children should be seen often upon entry into OHP

- Health screening visit within 72 hours of placement
- Comprehensive health admission visit within 30 days of placement
- Follow-up health visit within 60 to 90 days of placement

Children should be seen often while in OHP

- Monthly for infants from birth to 6 months
- Every 3 months for children aged 6 to 24 months
- Twice a year for children and teens aged 24 months to 21 years

Children should have comprehensive evaluations

- Mental health evaluation
- Developmental evaluation if < 6 years
- Educational evaluation if > 5 years
- Dental evaluation

Source. Szilagyi M, Rosen D, Rubin D, Zlotnik, S. Health care issues for children and adolescents in foster care and kinship care. *Pediatrics* 2015; 136(4): e1142-e1166.

DSS should also develop a focused training and resource package for kinship caregivers from nationally recognized sources, such as the AAP, Trauma Informed Partnering for Safety and Permanence-Model Approach to Partnerships in Parenting (TIPPS-MAPP), and the National Child Traumatic Stress Network Resource Parent Curriculum [17, 20-22]. CAMPs frequently noted that all OHP caregivers have identical responsibility, but kinship caregivers tend to be older, poorer, sicker, and less educated than foster caregivers [23, 24]. Therefore, DSS should pool resources that are available into a toolkit and post it online for all caregivers to access. For example, Fostering Health NC has Spanish-language resources for parenting after trauma, while the AAP has legal guides for grandparent kinship caregivers [17].

Limitations

Limitations include a small sample size, although it represented 57% of CAMPs in North Carolina. All participants were white and most were female, but our sample was diverse in terms of geographic location, years of experience, and type of medical practice. The demographic characteristics for our study are consistent with national data, which show that, on average, child abuse pediatricians are 28.5 years out from medical school, 80% white non-Hispanic, and 68% female [25]. Another limitation to consider is that CAMPs typically see the worst cases of maltreatment, which may bias responses. Additionally, most children in OHP are in private kinship care and unknown to OHP professionals. These children may primarily see a general pediatrician for care. It is our hope that our recommendations will help address communication barriers between general pediatricians and CAMPs. While this is the first qualitative study to assess the kinship care system from the perspectives of OHP professionals, future research on this topic would benefit from the perspective of other OHP professionals.

Conclusion

While this study reflects the complexity of OHP systems, it also reinforces the need to address this complexity from a united perspective that interweaves clear communication, coordination, and teamwork. The removal of a child from their home for suspected abuse is an opportunity to dramatically improve that child's life course. The degree of this improvement should not be muted by placement type. It is our hope that this study's recommendations can provide an initial guide to encourage interprofessional collaboration as a means of achieving well-being for all of North Carolina's children in OHP systems. NCMJ

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Acknowledgments

We acknowledge Lewis Margolis, MD, MPH, associate professor in the Department of Maternal and Child Health at the Gillings School of Global Public Health at the University of North Carolina at Chapel Hill, for his generous guidance and time. We thank Adam Svolto, former Director of Fostering Health NC for his thoughtful review of the manuscript, as well as members of the North Carolina Pediatrics Society Committee on Child Abuse and Neglect for their feedback. We thank all the dedicated professionals and community members who collaborate in caring for children in out-of-home placement, including social workers, medical professionals, and foster/kinship caregivers. Finally, we thank the child abuse medical providers who participated in our study.

The authors have no relevant conflicts of interest.

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