Korina Barry (00:04):

Thank you, everyone for tuning into the CASCW podcast. Today, I'm chatting with Dr. Kimara Gustafson, Kimara. How are you doing?

Dr. Kimara Gustafson (00:13):

I'm good. Thank you for having me. It's great to be able to share a little bit more about our work with the listeners and hopefully be able to continue to, lead to good connections within the university and the broader community.

Korina Barry (00:31):

Absolutely. Well could you start by introducing yourself and just sharing a little bit more with our listeners about who you are and kind of what your role is?

Dr. Kimara Gustafson (00:40):

Yeah, so I am a pediatrician here at the University of Minnesota Masonic Children's Hospital, just kind of a mouthful, but I also work in the Adoption Medicine Clinic, which is a specialty clinic here at the U. It's unique in that there's only a handful of clinics like ours in the nation. And ours is actually the oldest. It was founded over 30 years ago. And so historically, or the origins, I guess, of the clinic is that it was founded by Dr. Dana Johnson, and he founded it kind of out of his own necessity. He adopted his son from India, and was looking for resources to help better support his son and his family and realized that it didn't exist. And so founded it in the clinic originally was kind of focused more on international adoptees and their adoptive families.

Dr. Kamara Gustafson (01:42):

But, thankfully the clinic has kind of evolved and grown, as the community has evolved and grown within the adoption and kind of family community has changed. And so now we see both international adoptees, domestic adoptees, and children in foster care, kind of with, you know, the variety of paths either for reunification or kinship care or non relative adoption. And and we have been fortunate that we've been able to do much of this recent expansion from a grant from the Department of Human Services. So since 2018 we've created this comprehensive model that allows us to see these kids and families as, as part of a multi-disciplinary team. And then personally I came to this, I had a somewhat non-traditional path to med school, and then in med school knew that I wanted to do something related to pediatrics.

Dr. Kimara Gustafson (02:51):

I was able fortunately to get a dual degree in public health and pediatric or medicine. And so, but during my residency here at the U, I was fortunate to kind of find out about the clinic. And so then ultimately was able to join in terms of faculty, but came to it partly because my personal connection is I am internationally adopted from Korea. And so had kind of a personal interest and curiosity, but then that's definitely led more into my professional interest and, kind of where I hope to be able to share both personal experience and professional experience with these families.

Korina Barry (03:41):

Yeah. Thank you for sharing a little more with our listeners about yourself and, and kind of your, your journey to working within the clinic and for many of our, our primary audience, and the workforce we

support through our center, are front-line child welfare professionals who are working in child protection, foster care, and in the adoption area, and primarily domestic, you know, here in the us. And so I'm wondering if you could share a little bit more about the, what the services are or what some of that support you all offer looks like for, for those families who are involved in child protection for those children who are in foster care. And as you said, maybe, you know, maybe the permanency has looked, it looks different in many ways of whether that's reunification or, you know, transfer of legal custody or adoption. Just kind of within that part of our system here. If, so for professionals listening or other providers and advocates, and kind of thinking of like, okay, what services could we access for these, these kids and families?

Dr. Kimara Gustafson (04:56):

Yeah. So that's really where we've tried to develop kind of this, like I said, this multidisciplinary team. We in the last couple of years have created what we call the Comprehensive Child Wellness Assessment or the CCWE. And what we're doing is, excuse me, is we're bringing together both our medical professionals. So either pediatrician or pediatric nurse practitioner, developmental specialists, so it's, um, occupational therapist and then mental health support. So either a clinical psychologist or a clinical social worker, um, and, uh, we do what we're calling kind of a baseline assessment. So they're not necessarily a full diagnostic assessment from the developmental or the mental health perspectives, cause it's all within a framework of about an hour and a half to two hours. So we're really trying to squeeze a lot in for this assessment.

Dr. Kimara Gustafson (05:58):

But what we are hoping to do is to better kind of wrap ourselves around this child and the child's needs, and then the family, and, um, be able to start to make some of the referrals or recommendations to better support kind of that, that child and the family, and this role is out of. When we looked into the broader community to see what was being done, we realized that, that initial kind of removal assessment, the emergency assessment, that's done kind of, if a child is removed due to concern for their welfare, um, is pretty much focused on the physical exam. And looking at, you know, do they have signs of physical trauma or signs of, you know, physical neglect that needs to be addressed, but then there wasn't necessarily kind of a standard assessment in terms of the emotional and mental kind of aspects that may be at play.

Dr. Kimara Gustafson (07:05):

And so we're really trying to help fill in that need a little bit. And then what's very fortunate for us is that the mental health support we have, we're partnering with the birth to three early intervention, kind of mental health team that's looking at, you know, with the very much kind of trauma focused lens of what is this early potential trauma or toxic stress doing to the growth and development of this child, and then how do we help to better support both in short-term and long-term kind of that resiliency for the child and the family. Whether it be that they're going to be, permanency is with, you know, relative or non-relative or if reunification seems to be a good option. And then what I'm also excited about is that as we look out into the broader community, there's not a lot of necessarily clear guidance from kind of a similar comprehensive assessment for these children. And so that's where I feel like historically the, the clinic has been able to be kind of the model that's used nationally and in terms of international adopt and adoption care. And I'm, I'm really hoping that we can continue to be that model now, as we expand more into domestic and foster care, care of these children.

Korina Barry (08:47):

Yeah. And can you share how many children and families have been served? Like, you know, not exact numbers, but yeah. So,

Dr. Kimara Gustafson (08:56):

Um, so where we are, especially clinics, we only have clinic, it started as one half day a week, and now we've expanded to two half days a week. And slowly over the last couple of years, we've also been able to expand the number of providers available. Um, but that being said, I think in the last two years, since the grant started, uh, we saw over 2000 children. Um, and it's a mix of, um, kind of international adoptees, domestic and foster care, but predominantly the majority would be domestic or, um, foster care, uh, children. And, um, ideally, you know, once if, if we had kind of like wave my magic wand, we would ideally be seeing these kids a couple months after placement. Um, but right now we're just seeing kids kind of as they're able to come. So some of them have been in placement for, you know, I saw one that was on a Tuesday and they had been recently placed on the Sunday. But then other kids have been in their placement for years. So we see the whole gamut right now.

Korina Barry (10:12):

And what are some of the benefits that you've seen for those, you know, 2000 or more children that have been served through your services and, or how has taken care of both their psychological state, as well as their physical needs, you know, overall, like how have you seen that improve outcomes for children?

Dr. Kimara Gustafson (10:36):

Yeah. So it's a great question. And I think right now we're still working on kind of being able to, um, process the data to kind of, to back up that it is a value added to these kids. But, uh, I think just anecdotally, what we see is that, um, you know, that the families, I think have a better sense of the kind of extend to the need that these children have in terms of support. Um, and I feel like by us helping to reframe some of their behaviors or their, um, uh, kind of barriers that the kids are struggling with, um, it can help the families to be better advocates and also to kind of better understand their own child. So if the child is exhibiting, you know, kind of obstinate behavior, we can help to try to figure out is this because they're just a typical little toddler and they're, you know, three and they want to kind of control situation, or is this like actually a manifestation of their, um, and that they've had a history of, um, neglect or trauma that has resulted in this behavior and so able to help the families to kind of better understand that.

Dr. Kimara Gustafson (12:07):

And, you know, one of the questions oftentimes we get is how do we kind of parent the child and keep them safe and create safe boundaries and kind of parameters, but also continue to promote bonding and attachment. And we don't want it to necessarily always be punitive, but we can't have the child just have kind of run of the house, as maybe they had been used to, you know, in the previous setting, um, especially if there is issue of neglect. And so, um, helping to kind of work with the families, say here are some parenting techniques to kind of reframe, you know, so that it's not a time-outs scenario, but maybe, you know, having them work more into kind of how do we do like a rewards-based or a time in kind of parenting strategy, and see if that helps.

Dr. Kimara Gustafson (13:08):

And then definitely if it's if it's needed, we are able to make referrals for ongoing mental health support, both for the child, individual therapy or family therapy or both. Um, and similarly on the developmental side, if it's deemed that that baseline assessment is kind of flagging some areas, then we're able to make those referrals and kind of fast track to get the you know, get them kind of caught up or, or, um, better supported so that when, you know, if, if it's a younger child, when they are in getting ready to start school, they're kind of in a better place, or if it's a grade school child already, that, that family knows, okay, we need to really, you know, kind of try to fast track and, and partner with the school district to get the necessary support. Cause a lot of times is, you likely know, you know, this is, this transition has also resulted in a school transition too. So, you know, the families are kind of having to start all over and the school doesn't quite know what they're dealing with and they may or may not have access to that previous IEP or 504 if there was one.

Korina Barry (14:31):

Yeah. And in thinking about the kids that, you know, the, the over-representation of kids of color and other marginalized groups in the child welfare system within, you may be seeing through your clinic and services, like, how, where does like culture show up in the work you are able to do internally, and then are you able to do you have partnerships and referrals you're able to make for kind of culturally specific supports for, for these children?

Dr. Kimara Gustafson (15:09):

Yeah, so it's a great question. And I, I think that as much as we can, we are working with the families, you know, it kind of depends on the, the composition. So, you know, obviously if there's kinship, there's some raw kind of maybe distant, but some connection to the biological family. Um, and so maybe there's some kind of connection to or similarity or shared kind of experience. If they're, if the child's a person of color and then the family might be as well, but if it's a non-relative or domestic adoption or definitely for our international adoptees, I always try to kind of make a point of focusing on the culture of the child or, the culture that the child came from and is being kind of placed in, and then trying to help navigate community resources to say, how do we help them, especially because we do see a vast majority of our patients are actually from greater Minnesota.

Dr. Kimara Gustafson (16:29):

And so, and this is where I think sometimes I lean on my personal experience as well of seeing like, okay, if you live up in, you know, Iron Range, or if you're down in kind of Southwestern Minnesota, and here's this child of color, from my own personal experience, kind of making a guess that they might be even more of kind of a minority in this, you know, kind of newly placed environment. So making sure to talk to the family about how do we continue to support them and that if they do need mental health support, that that's kind of an area that will need to be supported as well, hopefully to the benefit of their mental health. So some of the local organizations, we partner a lot with MN Adopt, and Umoja and, other kind of cultural, specific, specific groups in the area that are looking at Latin X or, native American, or kind of Asian American.

Dr. Kimara Gustafson (17:40):

And then I talked to the families like, um, also about that. Definitely we want to make sure that they're kind of keeping that on the, the front of their mind, but that it doesn't, you know, that it can be kind of tailored to the age of the child too. And so if there's opportunities to participate in kind of family day, cultural events and things like that, that might be something that they could include kind of a larger

family. It doesn't have to, you know, not everything has to be just about, um, the one child that's kind of in front of me, but what I like about our clinic is that, and in pediatrics in general, I think we know that the child does not exist in a vacuum. And so in helping to try to support the family or the child, we need to make sure that that works within that family context too. So the support of the child, I think oftentimes kind of, broadens to be, you know, better supportive of the family and that might be other siblings or, you know, kind of other adult caregivers that are in the picture.

Korina Barry (19:00):

Yeah. And thinking about, kind of pathways and the pathways, children and families become involved in and access services through the clinic. What are some of the ways, you know, as, do you primarily see referrals from County agencies, you know, or families kind of coming on their own, just if you could share more of like how, how are folks accessing services?

Dr. Kimara Gustafson (19:27):

Yeah. And so I think prior to the grant, it was mostly like self-referral, or kind of word of mouth within the parent community. We historically have done, and we continue to do outreach events where we'll go and partner with, agencies like Children's Home Society or some of the adoption related camps that occur over the summer. But, definitely with the grant, we've been able to expand our outreach and so have been going out and just describing our services to the pretty much, I think we've done every County now in the state of Minnesota. So now a lot of our foster care and domestic adoption referrals are coming through case managers and County based. And we do with any child that comes through the clinic, regardless of kind of where they started and where they're going, we will do fetal alcohol spectrum assessment, again, similar to kind of the developmental and mental health assessment. And if it seems like they're at higher risk, we kind of can help to continue that referral as well. So we do also get kind of a subset of referrals looking specifically for FAS or kind of prenatal exposure assessment. And so occasionally we'll get that through like a community partner that's helping to partner with the biological family. You know, if, if a parent has now been able to get their own services, sometimes we'll get referral that way as well.

Korina Barry (21:14):

Yeah. And are there, do you all offer post reunification post-adoption services and supports and if so, kind of, what does that look like for, for families?

Dr. Kimara Gustafson (21:29):

Yeah, so definitely post adoption. So for our internationally adoptees and domestic adoptees, we do offer a service through the clinic where we'll do a pre-adoption assessment. That is a fee for service, kind of service that, but some depending on the agency, there are some grants available that families can inquire about to help kind of cover those costs. And what we do with those is we take kind of any available information on the domestic side It's hard because oftentimes they don't have the kind of pre pre-placement information, but if it is sometimes we'll have access maybe to birth records or kind of a redacted medical record of the biological mother. And so we kind of look through and try to help the family to just better decipher, you know, what do all these mean? And what does this mean in terms of possible support or kind of interventions that this child may need.

Dr. Kimara Gustafson (22:36):

And, and then post adoption for our international adoptees, we recommend that they be seen in our clinic for that initial assessment, usually within two to three weeks of placement, and then, but really we're happy to see them anytime kind of after they joined the family and similar for, for domestic adoption. Um, and then for foster care, we haven't done as much work following the families post-reunification, but definitely if a child's in our clinic through foster care, we're happy to continue to follow whether or not they find permanency through non-relative or domestic adoption. Um, and then that is an area that we're working on, developing more, is we now, just in the last two years, we now have a handful of kids that have been able to make that transition back to reunification. And so our partnering with the biological family and parents to try to help support, and that's an area where just kind of out of my own interest, I started doing some digging about, you know, what are the medical recommendations?

Dr. Kimara Gustafson (23:57):

And it's, it's kind of a, there's a void right now in terms of, you know, and oftentimes I think from a medical standpoint, from what I could find, it was like, Oh, well, you're back with your parents. So, you know, good luck and we'll see you later. So we're definitely trying to help to kind of fill that void because at least anecdotally, a couple of the kids that we've seen that have you know, currently are reunified just ended up being some of the kids that are, have a lot of higher needs. So knowing that there it's going to be a child that is going to need more support and resources. And then, you know, being reunified with parents were still doing their own kind of work. And so how do we help to really support them? So this is, can be as successful as possible.

Korina Barry (24:52):

Yeah. And, you know, as, knowing often for professionals and advocates that are supporting families and children involved in the child welfare system and trying to make referrals and get assessments done like FASD you know and other needs sometimes it, you know, capacity can be an issue and, you know it's not as easy to access this as sometimes people would think. And then I also am thinking now we're in a pandemic and I'm wondering, has the work you all are doing and the services you all are able to offer shifted so far during the pandemic, whether that's capacity or even just what that work looks like. And, and do you see any of that potentially, you know sticking, you know, more long-term or for awhile? I know we don't know a lot about what the coming months are gonna look like, but

Dr. Kimara Gustafson (25:52):

Yeah. So I think kind of a silver lining, if you can say it in that way, is that we were able to pivot pretty quickly to a virtual model. Recognizing that there are some things like some of the physical exam items that we need to do, aren't currently able to be done in a virtual manner. Um, but we are still able to do, I would say, you know, 85 to 90% of our assessment in a virtual manner. And so we really only had I think two weeks or so that we had to cancel clinic and we've been able to shift now. And capacity-wise, I think because of the virtual model, we've actually been able to increase capacity because there's more flexibility in terms of scheduling on our end and now everyone's home. So we were just like, well, you know, you let us know when might work.

Dr. Kimara Gustafson (26:52):

You know, if you can block off an hour in your week, where, we can try to work around it within reason. Um, and so our hope, and it looks pretty promising, especially because we know that a majority of our patients are coming from greater Minnesota, you know, on any kind of regular clinic morning, I would

say the average travel time for my families would be, you know, at least two hours to get to clinic. And in my first appointment is usually around eight. So these kids are getting up at five in the morning to come down or come up. And so, we would love to be able to continue to do at least a portion of it virtually. Um, and I think it looks like that that's going to be possible and then to kind of streamline so that the portions that need to be done in person kind of saves them some trips, you know, maybe instead of doing two or three trips, we can kind of condense different aspects of it into one.

Dr. Kimara Gustafson (28:02):

And then what's been also a silver lining. Is that within the mental health community, it's, it seems like they've been able to pivot relatively well to a virtual model as well. And so that's allowed, at least I know our mental health team, and then we partner closely with Fraser, in the mental health support. They too, they've been able to offer virtual mental health support. And so for families in areas where there's kind of a lack of options, I think that's been potentially value added. Um, and we know that, you know, there again are gonna be some limitations in terms of virtual mental health, but, a lot, especially for our younger kids, a lot of the work that our psychologists are doing is through observation. And so they were saying that it's actually been just as kind of effective, if not more so, because they're able to see these kids in their home environment. And so sometimes able to see, you know, sometimes the kids seem to be doing better because they're not in kind of this new or strange environment, but sometimes they can also see the behaviors that the parents are, you're kind of having to experience, but they don't display when they're outside of the home, but when they're in a safe environment, they're like just letting everything go. And so then the, you know, the parents don't feel like, Oh, you think I'm a crazy person because in person they're totally fine and quiet and content. And then at home, there's these rages and whatnot. And so our therapists are like, Oh yeah, no, I, I see what you're saying or, you know, that can just get a little bit more of a firsthand account of what's going on. So I think that's been definitely kind of a positive to come out of all of this. We know that, there's still some restrictions and limitations, definitely with the FAS evaluation, that's been more of an obstacle and we're still trying to navigate what that might look like. But I find that so far, the families that we've been doing virtual visits with seems like they felt like it's been value added. Um, and that you know, we're able to help to connect them to the community resources as available and in spite of everything.

Korina Barry (30:55):

Yeah. And for folks who are maybe listening and, and don't know what FAS, just thinking of that now may mean, and actually how prevalent, you know, the, the prevalence of that in some of our kids that are involved in child welfare and you know, end up seeking permanency in other ways, adoption. Um, what is that? And if you can say a little bit about that assessment and evaluation, that why that makes it a little hard to do that virtually?

Dr. Kimara Gustafson (31:30):

Oh yeah. Sure. So FAS is a stands for Fetal Alcohol Spectrum, and it's, uh, similar to autism or ADHD that it's a condition that definitely can have different presentations all the way from kind of mild to severe. The main diagnostic criteria are that there's known alcohol exposure during the pregnancy. And the second one would be that there's growth issues. So oftentimes it is severe and these kids can have difficulty growing appropriate Even if they're getting kind of the adequate caloric support, you know, in terms of the third one would be there's brain changes. So we know that FAS is kind of the number one cause of preventable brain damage in children. And what's tricky is that the fourth criteria is that there are characteristic facial features that can be seen again in the more kind of severe presentation of it.

Dr. Kimara Gustafson (32:43):

And so usually the main facial features are they have small eyes or the eyes appeared really wide set. But it has to do actually with the width of the eye. They have a really flat area kind of between the, the bottom of the nose and the upper lip, which we call the philtrum and then they have a thin upper lip. But we also know that you can have kind of a brain changes that impact cognitive functioning without having the visible physical facial features. And so this is something that we know is sorely underdiagnosed and kind of the understanding of it is, definitely not to a point where we would hope. And then the result is that these kids, their brains just don't function in the same way as maybe the kind of the non-exposed peers, but they don't have any physical evidence of that kind of brain dysfunction.

Dr. Kimara Gustafson (33:54):

Like you might think of with other syndromes, like, like down syndrome. It has kind of a physical manifestation. And so a lot of times the struggles come that either a caregiver or other adult figures like educators, the expectations that they're placing on the child are unattainable based on the child's capacity, but they don't quite know that if this hasn't been fully assessed. And so they feel like they're just always at odds with each other and the child themselves starts to recognize this, and then will start to potentially internalize some of that kind of negative reinforcement that they're getting either intentionally or unintentionally by the kind of environment that they're in. And so I feel like it's a very important assessment because the way I describe it to families, is it's similar to dyslexia in that someone who's dyslexic doesn't necessarily have the, the name or the word to associate, they just know they can't see the information in the way that they think they should, and so it's causing them to struggle. And if that's undiagnosed and their family also doesn't quite know like, how come you're not reading or how come you can't remember numbers. Um, and if that's kind of left undiagnosed, then it can snowball into other issues. And that's how I think of FAS. If we can make a good diagnosis early on and get support in similar to dyslexia, we can figure out ways in which to help that child to kind of figure out work arounds or compensate for the areas that they struggle a bit more. Um, but if not, it can lead to usually more mental health issues. Um, and you know, and things like school avoidance or kind of maladaptive behaviors as their way of trying to deal with what they're struggling with.

Korina Barry (36:17):

Thank you for breaking that down a little bit more and just kind of highlighting again, the importance of more of these fuller, more comprehensive assessments and identifying the needs of, you know, children, and especially children that have experienced trauma and lots of transition and helping support them and prepare them to, you know, live well in their new forever homes and, and whatever that permanency looks like for them. Is there anything else that you would like to share with our listeners, with the frontline kind of childwelfare professionals, other providers that are serving children? Anything else you want them to know about this work in the clinic?

Dr. Kimara Gustafson (37:08):

Yeah, I mean, I think that we would really be excited to be able to partner with kind of our frontline child welfare providers in the sense that, um, kind of when I think about what is the root of what I do, or what I hope to be doing is really to try to kind of repair and restore the resiliency in each of these kids. And I think it's easy sometimes to get caught up in all of the negative or kind of bad things that have happened thus far for some of our kids, and I don't want to minimize or negate that. But what, what helps me to kind of keep going day after day is knowing that both you know, in general, kids don't necessarily know different. And so when that's in a bad situation, unfortunately they don't know that

there's a potential for the good, but if we're able to help them to get into a better situation, I think that for the most part kind of a child's core is set up to try to grow and thrive.

Dr. Kimara Gustafson (38:30):

And so I feel like my work is really trying to get them into that situation. Um, and if we can kind of provide that nurturing that they need, then it is, um, there's that potential that they're going to, you know, when I come back for followup that they're like, Oh, you know, totally different kid, you know, in a sense, um, you know, so an example is, uh, I had a little three year old who was diagnosed with autism cause she had been left. She was non-verbal and was having rages. Um, but her history was, she had been essentially left for the first year and a half, uh, in a pack and play and unattended. And then once she got placed into her permanent family setting, you know, a year after she's, you know, just this bubbly, adorable, lovely child that really was able to kind of weather that experience and kind of come through. But the other thing that I just, I wanna kind of make sure that people know, and then I say this on when I go out and do community talks and whatnot is that I think historically we used to think kind of the end of the story was that permanency placement. And then after that, we can kind of just, you know, wipe your hands of the kid and move on to the next. Um, and now we know and definitely like personally, I believe that that's not definitely not the end of the, that's kind of the end of that chapter. And we have to kind of keep going to the next chapter. Um, and so capacity wise, getting back to kind of the capacity wise, we used to just see children kind of at the first placement and then send them back to their primary.

Dr. Kimara Gustafson (40:31):

But now we, I recommend the families that we see them more kind of periodically. Um, and the way that I think about it with families or talk about with families is their child is going to kind of continue to process their experiences based on their developmental stage. And so if they were removed as a young child, they've had the experience, but they might not know how to process it, but when they get to fourth or fifth grade, maybe something kind of triggers their memory going back to when they were a child, but they don't quite know how to make sense of it or when they hit adolescence. And now they're developmentally, you know, we expect them to go through kind of their identity development experience, you know, what does that mean to be adopted or had this history of foster care? So that's where I think, again, we need to continue to partner with the families and the community providers to say, this is something that is part of their narrative and we want to help to support them ongoing, as they're kind of moving into adulthood, because we know that from like the prenatal alcohol exposure or adverse childhood experiences, and the data on all that that's not going to change, that's going to be something that continues with, to have potential impact lifelong as well. So we need to be able to help them navigate kind of through this experience as best we can.

Korina Barry (42:18):

Yes. And for sure. And we talk about that a lot in the child welfare system side, too, of how do we, how do we get to a place where it doesn't just end at, you know, cases close, reunification happened, permanency was achieved. We all, you know, everyone needs ongoing support from their networks and these families that we're serving that are especially vulnerable. They need support too. And so how do we, how do we continue to support beyond, like you said, you know, when permanency is made and continue to support these children, you know, for years to come. And so I think that's a really great reminder and a great reminder on how do we partner and put our heads together and do that work together. So thank you.

Dr. Kimara Gustafson (43:10):
Yeah.

Korina Barry (43:11):
Well, and thank you for taking time to chat with me and to share more with our listeners and kind of our network about the adoption medicine clinic.

Dr. Kimara Gustafson (43:24):
Yeah. And I just also want to say, so some of the beauty of our clinic, we're a pretty close knit group you know, in terms of our staff. And so definitely if people have any questions, we're more than happy to have people email or call. And it's pretty easy to get to a person to have kind of a conversation. So if people just have questions, like, is this something that this child should be seen? We're not even sure if I'm we're in the right place, we're happy to even have conversations kind of at that stage of the process. So don't feel like that it just automatically has to be, you know, everyone has to kind of come to the clinic.

Korina Barry (44:08):
Great. Thank you.

Closing (44:14):
This podcast was supported in part by a grant from the Minnesota department of human services, children and family services division.