Integrated Healthcare for Youth in Foster Care: A Narrative Review

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ABSTRACT

Integrated healthcare models combining behavioral and primary care provide solutions for vulnerable pediatric populations, especially youth in foster care, facing disproportionately high rates of chronic conditions and mental health issues. This review synthesizes current literature to assess the impact of integrated care on health outcomes for youth in foster care. Findings suggest integrated care can reduce healthcare barriers, improve coordination, and improve health outcomes for these youth. However, literature gaps indicate a need for more research. Clinical practice implications include adopting coordinated, multidisciplinary care. Future research should standardize definitions and approaches to support the sustainability of these care models. J Pediatr Health Care. (2025) *XX*, 1–15

KEY WORDS

Healthcare disparities, vulnerable populations, delivery of healthcare, integrated, health services accessibility, mental health services

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Youth in foster care experience disproportionately high rates of chronic conditions, mental health challenges, and poorer health outcomes compared to their peers, largely related to exposure to adverse childhood experiences, fragmented healthcare, and unstable placements (Centers for Disease Control and Prevention [CDC], 2021; Clarkson Freeman, 2014; Council on Foster Care et al., 2015; Turney & Wildeman, 2016). Their incomplete and often inaccessible health histories, coupled with disruptions in care coordination between child welfare and healthcare systems, further exacerbate barriers to consistent, high-quality healthcare (Keefe et al., 2020; Lamminen et al., 2020; Turney & Wildeman, 2016). Recognizing these challenges, the American Academy of Pediatrics (AAP) and Healthy Foster Care America released foundational care guidelines in 2005 (Table 1) and have endorsed integrated care as the gold standard healthcare delivery model for youth in foster care (AAP, District II, New York State, Task Force on Health Care for Children in Foster Care, 2005; Lammimen et al., 2020). Despite these guidelines, inconsistent implementation and limited research on standardized integrated care models persist, leaving a critical gap in evidence-based practice.

Integrated care is an evidence-based healthcare delivery model that combines coordinated primary care with mental healthcare and other services, utilizing a multidisciplinary approach to comprehensively address the complex physical, behavioral, and emotional needs of youth in foster care (Espeleta et al., 2020; Lamminen et al., 2020). Organizations, such as the National Association of Pediatric Nurse

TABLE 1. Healthcare recommendations for children in foster care or who have been adopted from Health Organizations and the State of Michigan

Care recommendations	American Academy of Pediatrics[a]	National Association of Pediatric Nurse Practitioners[b]	Healthy Foster Care America[b]
First visit	72 hours	72 hours	72 hours
Initial comprehensive	30 days	30 days	30 days
Follow up	60–80 days	60–90 days	60–90 days
Ongoing comprehensive (Birth to 6 months)	Every 30 days	Every 30 days	Every 30 days
Ongoing comprehensive (6–24 months)	Every 3 months	Every 3 months	Every 3 months
Ongoing comprehensive (24 months to 21 years)	Every 6 months	Every 6 months	Every 6 months
Acute/episodic	As needed	As needed	As needed
Mental health	30 days	30 days	30 days
Developmental (<6 years old)	30 days	30 days	30 days
Educational (5–21 years)	30 days	30 days	30 days
Dental	12 months old then every 6 months	12 months old then every 6 months	12 months old then every 6 months
Trauma-informed care	Yes	Yes	Yes
Integrated (model varies)	Yes	Yes	Yes

[a]AAP guidelines are currently under review with anticipated updates in 2025.
[b]AAP guidelines were developed in collaboration with Healthy Foster Care America, and in May 2022 NAPNAP endorsed the AAP standards of care for children in foster care in an organization position statement.

Practitioners (NAPNAP), emphasize the critical need for integrated, trauma-informed models to improve health outcomes and increase surveillance for this vulnerable population (NAPNAP Partners for Vulnerable Youth Alliance for Children in Foster Care, 2023). The National Child Traumatic Stress Network defines trauma-informed care (TIC) as a medical care approach in which all parties involved assess, recognize, and respond to the effects of traumatic stress on patients and caregivers (Duffee et al., 2021). Given the high prevalence of trauma among youth in foster care, TIC is an essential component of integrated care models, helping to mitigate trauma's effects, promote resilience, and enhance care delivery (Duffee et al., 2021). However, despite the recognized benefits of integrated care, limited research and a lack of consensus on standardized models hinder widespread adoption (Karatekin et al., 2014).

In late 2023, a Midwest university received funding to evaluate the community need and feasibility of integrated primary and mental health care for youth in foster care or who have been adopted. This launched a collaborative, interprofessional team, with leaders from community organizations such as public housing, education, nonprofit, and government child welfare agencies, and various healthcare organizations, capturing a broad scope of stakeholders vested in this population. Given the urgent need to address these gaps, this narrative review was selected as the most appropriate method to rapidly synthesize the current literature and identify emerging themes in integrated care for youth in foster care. The key question guiding this review is:

1. How do integrated care models affect physical and mental health access and outcomes for youth in foster care compared to traditional pediatric primary care models?

METHODS

This narrative review was guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Page et al., 2021) and conducted using PubMed and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Medical Subject Headings (MeSH) terms and related keywords were used to identify literature addressing the intersection of the child welfare system and healthcare integration (Table 2). TIC was not included as a search term, as the focus was on integrated care models regardless of TIC practices. This review is limited to full-text, peer-reviewed articles published within the last 10 years and focused exclusively on integrated care models for youth in foster care in the United States (US), thereby defining the boundaries and scope of the investigation. For purposes of this review, integrated care is determined by the authors as the coordinated delivery of primary and mental health services via multidisciplinary healthcare teams. Boolean operators, quotations, and keyword combinations refined the search with automatic filters applied.

The initial search yielded 981 articles (Figure). After applying filters, 48 abstracts and titles were screened, leaving 18 for full-text review. An additional 16 articles were identified through reference lists and the project lead's repository, bringing the total to 34 articles reviewed for eligibility. Articles were selected based on three criteria chosen to capture the most relevant and current evidence: (1) relevance to

TABLE 2. Search terms

	Population keywords (“ ”)	Intervention keywords
PubMed	Foster Home Care [MeSH], Child, Foster [MeSH], Adoption [MeSH], Child Custody [MeSH], Child Welfare [MeSH], Child Protective Services [MeSH], child protective service, child protective services, child welfare agency, child welfare agencies, kinship care, foster care, foster child, foster youth, foster children, foster family, foster families, foster parent, foster parents, foster mother, foster father, foster sibling, foster sister, foster brother, adopted child, adopted children, adoptive child, adoptive children, adoptive parent, adoptive parents, adoptive mother, adoptive father, adoptive sibling, adoptive family, adoptive families	Delivery of Health Care, Integrated [MeSH], integrated health care, integrated delivery system, integrated model, integrated care, wrap-around, collaborative care, coordinated care, horizontal integration
CINAHL	(MH Foster Home Care), (MH Foster Parents), (MH Child, Foster), (MH Child, Adopted), (MH Adoptive Parents), (MH Adoption+), (MH Children of Impaired Parents+), (MH Family Functioning), (MH Child Welfare+), (MH Child Custody), child protective service, child protective services, child welfare agency, child welfare agencies, kinship care, foster care, foster child, foster youth, foster children, foster family, foster families, foster parent, foster parents, foster mother, foster father, foster sibling, foster sister, adopted child, adopted children, adoptive child, adoptive children, adoptive parent, adoptive parents, adoptive mother, adoptive father, adoptive sibling, adoptive family, adoptive families, foster mom, foster dad, foster brother, adopted sibling, adopted brother, adopted sister, adoptive mom, adoptive dad, adoptive brother adoptive sister	(MH Health Care Delivery, Integrated), integrated health care, integrated delivery system, integrated model, integrated care, wrap-around, collaborative care, coordinated care, horizontal integration

primary care and mental health integration, (2) focus on US healthcare and/or foster systems, and (3) targeting pediatric populations. The inclusion criteria were justified by the need to capture contemporary trends, given the limited literature on integrated care models for youth in foster care and the 2005 AAP guidelines, while encompassing related studies on pediatric populations where direct evidence was lacking. Additionally, the exclusion of international publications was necessary due to the complexity and variability of healthcare and child welfare systems unique to the US. Only four articles specifically addressed integrated care within foster care settings. Eleven articles were excluded for addressing unrelated services or international health systems, leaving 23 studies to inform the review (Table 3).

Automation tools were not used in this process; however, an electronic shared drive was used as a secondary source of

FIGURE. Prisma search flowchart.

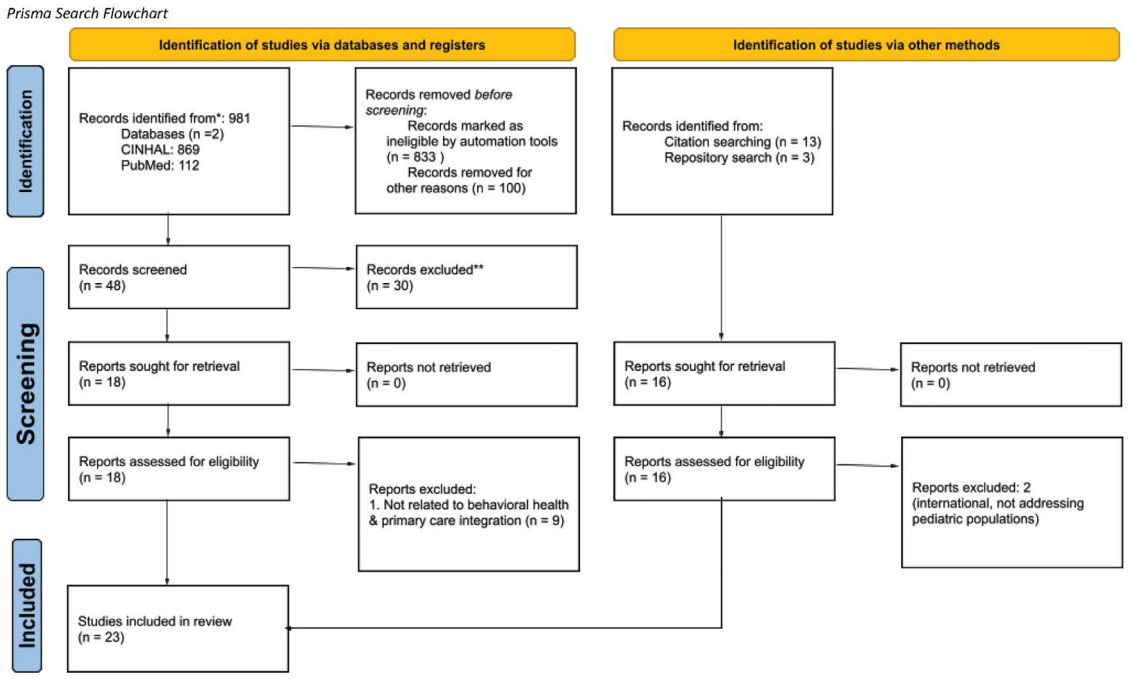

TABLE 3. Literature review table

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
1	Asarnow et al.	2017	Reviews the concept of patient-centered medical homes and their application to pediatric healthcare and behavioral health.	Literature review; level 7	n/a.	• Pediatric Patient-Centered Medical Home (P-PCMH) improves access, quality, and effectiveness of behavioral health and primary care. • Describes various models of integrated care. • Recommends further research.
2	Asarnow et al.	2015	A systematic meta-analysis of integrated medical-behavioral care models to determine if models lead to improved outcomes.	Systematic meta-analysis; level 1	31 randomized control trials, 35 intervention-control comparisons, 13,129 participants.	• Interventions targeting diverse behavioral health needs showed greater benefit than those focused on individual treatments (e.g., substance use). • The strongest benefit observed is in collaborative care with team-based treatment. • Small sample sizes were a limitation. • Treatment trials had a moderate effect size (d = 0.42), with a 66% probability of better outcomes. • Collaborative care interventions had a stronger effect than usual care (d = 0.63), with a 73% probability of better outcomes.
3	Babajide et al.	2020	Provides an overview of mental health treatment gaps and barriers for young adults, promoting research on integrated health models.	Literature review; level 7	12 articles were reviewed with ages ranging 12–60+. Only five articles are specific to young adulthood (18–25).	• The collaborative care model improves access, service completion, outcomes, and satisfaction; better than facilitated referrals. • Barriers for young adults: stigma, system complexity, lack of continuity, coordination, and provider training. • Opportunities: CMS reimbursement for care coordination and collaborative models. • Challenges: fee structures, personnel time, reimbursement, and confidentiality concerns.
4	Burke et al.	2015	Presents case studies evaluating the importance of care coordination and collaborative care for a vulnerable population.	Presentation of two case studies/level 7	Illustrates the importance of care coordination and the benefits of a coalition primed to assist using two case studies.	• Policies are needed for multi-sector collaboration to support trafficked minors. • Care coordinators ensure communication and protect privacy. • Quality and accountability are difficult in resource-limited settings
5	Burkhart et al.	2019	Identifies RCTs and quasi-experimental studies on the relationship between integrated care, increased access, treatment engagement, and improved mental health outcomes.	Systematic review; level I	n = 6; studies (published before August 15, 2019) on youth (ages 0–21) accessing mental health care via collaborative or integrated care models, comparing with usual care. Studies in English.	• Integrated/collaborative care improves mental health treatment initiation and completion rates, boosts patient satisfaction, and enhances adaptive behavior and mental health outcomes.

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
6	Chen et al.	2021	Evaluates the link between mental health treatment initiation after a primary care provider's (PCP) initial diagnosis of attention deficit hyperactive disorder (ADHD) and/or major depressive disorder (MDD), and the type of integrated care arrangement (ICA).	Retrospective cohort analysis; level 4	*n* = 4,203 ADHD and 298 MDD cases, ages 4–18, newly diagnosed by a PCP with a continuous health plan enrollment within 90 days post-diagnosis, and an identifiable PCP practice location.	• Three ICAs: non-co-located, co-located, and co-located/co-affiliated PCPs. • Co-located/co-affiliated PCPs more likely to provide guideline-recommended psychotherapy. • Children in co-located/co-affiliated settings twice as likely to receive guideline-recommended psychotherapy. • Proximity alone is insufficient for collaboration; only 7%–15% received treatment in co-located but nonaffiliated settings. • Most ADHD diagnoses and treatments were managed by PCPs (85%–90%). • Black and Hispanic children received less treatment than white counterparts regardless of model. • Primary care is more accessible with less stigma, but barriers include lack of PCP training and referral options.
7	Espeleta et al.	2020	Discusses the implementation of pediatric medical homes for foster care youth based on AAP guidelines, emphasizing the need for a unique model and adaptations.			• PMH model should provide comprehensive, continuous care for foster youth. • Adaptations for foster care include accessibility, family-centered, compassionate, culturally effective, and coordinated care. • Coordination required both within and outside provider disciplines. • Logistical framework provided for establishing PMH; future research needed for best practices.
8	Greiner et al.	2017	Describes the development of a health model to meet the needs of foster care youth.	Case report; level 7	Single healthcare model described.	• CHECK model: sustainable collaborative care with behavioral health screening in primary care for foster children. • Addressed four barriers: lack of health records, geographic instability, healthcare cost, and collaboration. • Added a social worker for PTSD prevention (ages 6+) and collaboration with a community agency for younger children. • Developed a referral system: family contact within 24 hours, referral within 1 week.
9	Heath et al.	2013	Reviews levels of integrated healthcare and proposes frameworks for classifying them.	REPORT; level 7	n/a.	Key differences in care types: communication frequency, relationships and skills, physical proximity, and practice structure

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
10	Hodgkinson et al.	2017	Discusses the impact of poverty on mental health, barriers to care, and how integrated behavioral health models can improve access and outcomes for children and families in poverty.	REVIEW; level 7	n/a.	• Poverty affects well-being: mental health, physical health, development, healthcare access, and utilization. • Disparities noted among minority youth in poverty, despite most impoverished children being white. • Extended poverty linked to poorer health outcomes and reduced healthcare access. • Barriers to mental healthcare identified; integrated behavioral healthcare seen as a promising solution to improve outcomes. • Recommendations: changes needed in education/training, clinical infrastructure, and multidisciplinary teams.
11	Kolko et al.	2014	Assesses the efficacy of collaborative care for behavior problems, ADHD, and anxiety.	Cluster randomized trial; level 2	8 pediatric practices, 74 providers (67 physicians, 6 NPs, 1 PA), 4 social workers, and 321 patients.	• Collaborative care is linked to higher rates of treatment initiation, completion, improved behavior, reduced parental stress, and issue remission. • Based on the chronic care model. • Collaborative care is feasible, improves access to services, enhances completion rates, and boosts outcomes and satisfaction.
12	Kolko and Perrin	2014	Briefly reviews clinical trials and intervention studies in pediatric primary care to document the integration of alternative models for delivering behavioral services.	Review/level 7	Care delivery models for addressing behavioral health needs in general pediatric populations.	• Four reasons to provide behavioral health (BH) in primary care: ○ BH is prevalent and burdensome in pediatrics. ○ Specialty mental health services have limitations. ○ BH is a chronic condition better managed with collaborative care. • Collaborative care models are feasible, improve access and service completion, and enhance outcomes and satisfaction. • Collaborative care shows advantages over facilitated referrals.
13	Lamminen et al.	2020	Describes an integrated healthcare model based on 2005 AAP guidelines and lessons learned, addressing the healthcare and behavioral health needs of foster care youth.	Narrative; level 7	Two clinic models—one urban and one suburban. Staff: Behavioral health experts, primary care providers, CPS liaisons, and physical/behavioral health specialists. Approach: Trauma-informed care.	• Highlights physical and behavioral health disparities in foster care children. • Integrated care is the gold standard for youth in child welfare, with lessons learned and challenges noted. • Challenges: financial barriers, infrastructure, ethics, training, and research for children with protected status. • Emphasizes the link between clinical, academic, and community spaces in foster care.

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
14	Loria et al.	2021	Discusses the impact of poverty on mental health care access and barriers, and explores integrated behavioral health models as opportunities to improve access and outcomes.	Literature review and report; level 7	n/a.	• Poverty impacts children's health, well-being, care access, and mental health outcomes. • Barriers to mental healthcare: access to records, fragmented info, specialized knowledge, trauma-informed care, geography, sociodemographic status, poor collaboration, insurance, visit length, and social/psychological factors. • Integrated healthcare improves access and care coordination; successful models highlighted. • Barriers: time, space, billing, training, and competing priorities. • Recommends policy changes in education, training, and infrastructure to improve mental health care access.
15	Malik et al.	2022	Discusses collaborative mental healthcare services.	Narrative review; level 7	n/a.	• Identifies mental health disparities and treatment gaps in the pediatric population. • Describes integrated care models and case examples. • Barriers to collaborative care: communication, training, financial constraints, and policy.
16	McLeigh et al.	2022	Explores pediatric integrated care (PIC) models, subpopulations served, outcomes measured, and strategies used to assess their effectiveness, aiming to determine if various models result in positive outcomes.	Scoping review/level v	English, peer-reviewed articles (January 1, 1994 to June 30, 2020) on pediatric, child, or adolescent integrated, collaborative, or co-located care, reporting on outcomes from PIC as defined by AHRQ.	• Pediatric integrated care PIC can improve access and quality of behavioral health care. • More research needed to determine the most effective models and cost-efficient policies. • Definitions and types of integrated care vary, but outcomes are generally positive across the literature.
17	Miller et al.	2014	Appraises the literature to identify the range of services behavioral health providers offer and evaluates their potential scope in primary care settings.	Systematic literature review; level 5	The literature search included 241 articles, with 160 on mental health, 17 on health behavior, and 64 on both mental health and health behavior.	• Behavioral health providers support primary care, addressing psychological needs that impact health outcomes. • Examples: addressing psychosocial barriers, lifestyle changes (irritable bowel, insomnia, weight management), mental health, substance use, and comorbid conditions. • Fully integrated systems increase the likelihood of receiving behavioral health care. • Patients with serious illness have lower no-show rates in primary care compared to community mental health settings. • Depression is the most common focus for behavioral health providers. • Policy implications: need for full integration and billing for a wider range of behavioral health services.

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
18	Njoroge et al.	2016	Summarizes current data on innovative integrated behavioral health models in pediatric primary care.	Systematic literature review; level 3	22 unique articles identified from PSYCHINFO, PubMed, and article reference reviews.	• Integrated care includes diverse services; it's not one-size-fits-all. • Patient and practice needs determine the appropriate model, potentially using a hybrid approach (e.g., collaborative screening and ongoing consultation). • Model development varies by patient demographics, payer mix (Medicaid vs. private), and access to mental health referrals. • Practical implementation may involve separate billing systems, leading to co-pays and fees not covered by grants.
19	Oppenheim et al.	2016	Analyzes experiences of Project LAUNCH grantees, describing 10 elements of integration and challenges in promoting health and preventing social, emotional, and behavioral problems, focusing on integrating behavioral health into primary care.	Qualitative case study approach designed to examine models of integrated care being implemented in primary care settings by a subset of Project LAUNCH grantees	6 grantees; qualitative data collected using telephone interviews; four follow-up, open-ended survey questions, and content analysis of semiannual progress reports.	• SAMHSA's LAUNCH Project has 5 core strategies: ◦ Developmental/behavioral screening in child-serving settings ◦ Mental health consultation in early education ◦ Enhanced home visiting (focus on social/emotional development) ◦ Family strengthening and parent support ◦ Integration of behavioral health into primary care • Study findings: More work needed in financing and building an evidence base for effectiveness.

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
20	Rafla-Yuan et al.	2022	Analyzes current US behavioral healthcare systems, evaluates evidence for change, and provides recommendations (policy, direct care, integration) with a focus on BIPOC youth.	Expert opinion; level 7	n/a.	• Trauma-informed practices are essential for integrated care models. • BIPOC youth are vulnerable due to environmental and familial factors, with racism contributing to disparities like unstable housing, illness, and incarceration. • Integrating psychiatric care into medical settings improves access for minority groups. • Calls for patient-centered, culturally humble, trauma-informed, and holistic care, with criticism of over-reliance on medication. • Disproportionate increase in psychiatric diagnoses and suicide among BIPOC, especially Black youth. • Toxic stress linked to social determinants of health created by structural racism. • Advocates for education, child welfare, legal system, and government collaboration, with policy changes to promote healthier communities. • Compares integrated care models: collaborative care, behavioral health clinician model, and Child Psychiatry Access Programs.
21	Richardson et al.	2014	Determines if collaborative care intervention improves outcomes for adolescents with depression.	Randomized clinical trial; level 2	Sample: 101 youth. Inclusion: Adolescents with PHQ-9 score ≥10, major depression criteria, or second positive PHQ with Child Depression Rating Scale >42. Exclusion: Non-English speaking, suicidal plan/attempt, bipolar, substance misuse, psychiatrist involvement, developmental delays.	• Higher rates of evidence-based depression treatment and improved outcomes vs. traditional care. • Intervention led to improved functional status, higher depression remission, greater satisfaction, and more adherence to quality standards for therapy and medications. • Screening alone (following current guidelines) did not consistently lead to appropriate mental health treatment.
22	Richardson et al.	2017	Reviews literature on behavioral health integration for adolescents and young adults to identify research gaps.	Systematic review; level V	21 articles on patients aged 13–25, focusing on integrated care and primary care-led behavioral health interventions. Exclusion: articles without collaboration or in broader school settings.	• Limited literature on integrated care models for adolescents and young adults, despite strong evidence in adults. • More research needed on intervention effectiveness, impact of developmental age, effective integrated care models, provider training strategies.

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TABLE 3. (*Continued*)

#	Study	Year	Purpose	Article type and level of evidence	Sample	Major findings
23	Spencer et al.	2019	Appraises literature on four off-site pediatric integrated mental health care models (direct/indirect, in-person/remote) using eight implementation outcomes and identifies factors affecting successful implementation and sustainability.	Scoping review/systematic literature review not limited to RCTs; level 3	39 articles from 24 off-site programs using various study models and implementation outcomes. Inclusion: peer-reviewed articles on collaborative care, primary care, mental health in children/adolescents (50% of study population under 18). Data from Cochrane, Embase, MEDLINE, PsycInfo, and Web of Science.	• Three main off-site integrated care models: direct in-person (partnerships), direct remote (telepsychiatry/phone consults), and indirect remote (child psychiatry access programs). • Direct in-person, direct remote, and indirect remote models were highly accepted by families and providers. • PCP acceptability increased with strong interdisciplinary communication, reliable resources, ongoing support, and standardized care algorithms. • Off-site models were more suitable for less complex diagnoses (e.g., ADHD, depression); PCPs were less comfortable with complex cases. • Barriers: funding, reimbursement, space for on-site clinicians, professional isolation, and technology costs. • Mental health is a leading cause of youth morbidity, yet there is a service gap. Off-site integration can reduce barriers to accessing care.

communication. The shared drive included thematic findings from each reviewer and a structured table for data extraction summarizing each article's level of evidence, purpose, findings, and key definitions. Each reviewer independently identified key concepts and patterns across the included studies. An iterative consensus was held to acknowledge and balance personal perspectives, ensuring reflexivity throughout the review process. The process continued until thematic saturation was achieved, evidenced by the emergence of no new themes, resulting in an initial set of 15 themes. These themes were systematically compared, refined, and merged through additional consensus discussions, ultimately condensing them into five major themes that adequately represent the literature (Table 4): *Trauma-informed care, mental healthcare access and utilization, implementing integrated care, policy reform for sustainable integrated care, and need for research.*

RESULTS

This review incorporates evidence from randomized controlled trials, meta-analyses, systematic reviews, cohort studies, and case reports. Most included literature comprises narrative reviews or expert opinions, contributing to the five key themes. These themes explore how integrated care impacts physical and mental care access and outcomes for youth in foster care compared to traditional pediatric primary care, concluding with recommendations for research and policy changes. Terms like "mental health" and "behavioral health" are often used interchangeably in the literature, reflecting variations based on the pediatric populations and diagnoses addressed. This review adopts this interchangeable usage to maintain consistency with the terminology applied across the studies.

Trauma-Informed Care

Although not a primary aim of this review, TIC emerged as a key theme in addressing the complex healthcare needs of vulnerable pediatric populations, particularly youth in foster care. Five articles discussed or emphasized the necessity of TIC in managing the unique medical and mental health challenges faced by vulnerable pediatric populations. Youth in foster care experience disproportionately high rates of chronic conditions, behavioral health concerns, and unmet healthcare needs, underscoring the importance of coordinated, trauma-informed approaches (Loria et al., 2021; Lamminen et al., 2020). Research demonstrates that toxic stress and adversity significantly impact neurodevelopment, increasing the risk of social, cognitive, and behavioral difficulties (Oppenheim et al., 2016). Effective TIC requires collaboration across multiple sectors, including healthcare providers, families, policymakers, and community organizations (Rafla-Yuan et al., 2022). Structural competency among clinicians is also essential in addressing racial and cultural disparities, particularly for Black, Indigenous, and People of Color youth, who often experience trauma not captured by standard assessments (Rafla-Yuan et al., 2022). Integrating TIC into primary and mental healthcare is critical

TABLE 4. Themes

Theme I: Trauma-informed care: *Trauma-informed care (TIC) emphasizes specialized trauma-focused interventions and interdisciplinary collaboration to mitigate the long-term effects of trauma and improve care outcomes. It is a critical component of integrated care models for youth in foster care.*

Theme II: Mental healthcare access and utilization: *Access to mental and behavioral healthcare is hindered by various barriers. The literature highlights the need to address individual and systemic barriers to improve healthcare access and outcomes. Individual barriers include geographic instability, financial constraints, stigma, and insurance coverage. System limitations include short appointment times, fragmented records, lack of cross-sector collaboration, and inadequate provider training on trauma and mental health. Integrated care effectively addresses barriers to healthcare access in vulnerable pediatric populations, but more exploration is needed for youth in foster care.*

Theme III: Implementation of integrated care: *The implementation of integrated care models for foster youth involves overcoming systemic barriers while leveraging key facilitators to ensure success. Various models of integrated care have demonstrated improved health outcomes. Barriers include payer systems, infrastructure limitations, and confidentiality concerns. Facilitators involve teamwork, communication, shared resources, and systemic changes. Various models are described, including co-located and telehealth services, showing improved access, treatment initiation, and behavioral health outcomes, particularly for conditions like ADHD and depression.*

Theme IV: Policy reform for sustainable integrated care: *Comprehensive reform is necessary to sustain integrated care for foster youth. Key areas include Medicaid reimbursement, provider training, and multi-sector collaboration between healthcare, social services, and education. Breaking down silos across these sectors is crucial for delivering holistic care.*

Theme V: Need for research: *The literature reveals a lack of high-quality research on integrated care for foster youth, especially randomized controlled trials. More research is needed to assess integrated care models' long-term benefits, developmental impact, and cost-effectiveness. Studies should also focus on expanding beyond depression to cover other mental and behavioral health conditions.*

for mitigating the effects of adverse childhood experiences and improving outcomes for foster youth (Burke et al., 2015; Rafla-Yuan et al., 2022). Despite its significance, several barriers hinder the widespread implementation of TIC, including inadequate provider training, limited appointment times, and a shortage of trauma-informed mental health professionals (Oppenheim et al., 2016).

Mental Healthcare Access and Utilization

Ten articles discussed barriers to mental healthcare access and utilization among vulnerable pediatric populations, particularly youth in foster care, and identified integrated care as a potential solution to these challenges. Findings highlight both individual and systemic obstacles contributing to these disparities in care, including inconsistent access to services, coordination difficulties across multiple systems, and a shortage of providers trained in trauma-related mental health care (Greiner & Beal, 2017; Loria et al., 2021; Malik et al., 2022). Without timely and integrated support, youth in foster care face increased risks of unmet healthcare needs, delayed treatment, and poor long-term outcomes (Babajide et al., 2020; Burkhart et al., 2019; McLeigh et al., 2022).

Youth in foster care experience unique challenges that disrupt healthcare continuity, including frequent placement changes, incomplete medical records, and difficulties navigating multiple service systems (Greiner & Beal, 2017). These barriers are compounded by financial constraints, insurance limitations, inflexible appointment times, childcare responsibilities, frequent visits, and long wait times, particularly for mental health services (Loria et al., 2021; Malik et al., 2022). Many youth rely on primary care providers as their main source of mental health support. Yet, most providers lack adequate training in TIC, developmental disorders, and behavioral health issues (Oppenheim et al., 2016). Adolescents transitioning into adulthood face additional risks, including loss of insurance coverage, the stigma surrounding mental health care, and gaps in adult mental health services (Babajide et al., 2020; Burkhart et al., 2019; Malik et al., 2022; McLeigh et al., 2022). As previously noted, disparities are especially pronounced among Black, Indigenous, and People of Color youth, who experience higher mental health needs but lower access to high-quality care (Chen et al., 2021; Hodgkinson et al., 2017). These populations are also more likely to experience trauma that standard screening tools fail to capture, further limiting their access to appropriate services, and are less likely to seek care or access high-quality mental healthcare when they do (Rafla-Yuan et al., 2022; Hodgkinson et al., 2017).

Systemic challenges further restrict mental healthcare availability. The historical separation of mental and physical health services has further hindered access to care, underscoring the need for integrated healthcare approaches (Miller et al., 2014). Short appointment lengths, reimbursement limitations, and a shortage of specialized mental health professionals exacerbate these gaps, often leaving youth untreated or inadequately supported (Burkhart et al., 2019; Hodgkinson et al., 2017; Loria et al., 2021). Additionally, fragmented information-sharing systems hinder continuity of care, as medical records are often inaccessible across healthcare and child welfare agencies, creating further challenges in treatment coordination (Burkhart et al., 2019; Hodgkinson et al., 2017; Loria et al., 2021; Oppenheim et al., 2016). Consequently, many youth with mental health disorders remain undiagnosed or untreated, with primary care providers ill-equipped to meet their complex needs. For instance, only 7% of children diagnosed with attention deficit hyperactivity disorder in primary care settings received guideline-recommended psychotherapy, illustrating significant gaps in care quality (Chen et al., 2021). Barriers to mental healthcare are even more significant for youth in foster care, where complex care needs, low reimbursement rates, and legal concerns, such as testifying in court, can deter providers from offering services (Chen et al., 2021; Spencer et al., 2019; Lamminen et al., 2020). Embedding mental health services

within primary care settings closes training gaps, improves access, reduces stigma, and enhances provider coordination (Burkhart et al., 2019; Loria et al., 2021; Malik et al., 2022; Njoroge et al., 2016). Integrated care models also address broader social determinants of health, such as food insecurity, housing instability, and family mental health challenges, which significantly impact well-being and reduce the risk of child maltreatment (Hodgkinson et al., 2017).

Implementing Integrated Care

Ten articles examined the implementation of integrated care models to improve access and outcomes for youth in foster care. Integrated care offers a promising solution to mental healthcare barriers by embedding mental health services within primary care settings. However, systemic challenges, including financial constraints, workforce shortages, and fragmented care coordination, can impede implementation. The literature illustrates obstacles and key facilitators influencing the success of integrated care models, particularly for youth in foster care.

Healthcare fragmentation remains a significant barrier to integrated care, with insurance limitations, service delays, and provider shortages restricting access (Kolko & Perrin, 2014). Payer systems often fail to support care coordination, team-based approaches, or quality monitoring, making the sustainability of integrated healthcare models difficult (Asarnow et al., 2017). Additionally, reimbursement structures, financial constraints, and confidentiality concerns present significant challenges (Babajide et al., 2020; Malik et al., 2022). For youth in foster care, financial sustainability remains a key concern. Strategies such as Medicaid reimbursement, child welfare contracts, and philanthropic funding have been proposed to support long-term care integration (Greiner & Beal, 2017). Furthermore, multi-sector collaboration involving education, housing, and social services strengthens the reach and impact of integrated care models (Burke et al., 2015).

Defining integrated care is complex, with varying terminology across disciplines. The Substance Abuse and Mental Health Services Administration framework identifies six levels of integration, from minimal collaboration to fully integrated practices (Heath et al., 2013). Higher levels of integration, such as co-located, team-based models, are associated with improved care coordination and treatment planning, particularly for youth with complex mental health needs (Malik et al., 2022; McLeigh et al., 2022; Njoroge et al., 2016). Some models classify integration by provider collaboration levels, incorporating on-site or telehealth services and multisector partnerships to address broader social determinants of health (Burke et al., 2015; Chen et al., 2021; Kolko & Perrin, 2014; Rafla-Yuan et al., 2022). Among integrated care models, co-located services, where mental health providers are embedded within primary care settings, offer the highest level of integration, improving communication and reducing logistical barriers (Spencer et al., 2019). However, off-site telehealth models provide a practical alternative, particularly for areas with limited infrastructure.

Despite these challenges, several key facilitators support the successful implementation. Provider training, infrastructure development, and interdisciplinary teamwork are essential to establishing sustainable integration efforts (Hodgkinson et al., 2017). Asarnow et al.'s (2015) meta-analysis found that team-based care and evidence-based treatment algorithms produced the most significant benefits. Successful models rely on shared resources, such as staffing and space, as well as enhanced provider communication and systemic practice-level changes to support co-managed care (Oppenheim et al., 2016; Malik et al., 2022; McLeigh et al., 2022).

Evidence indicates that integrated care improves pediatric mental health outcomes, enhancing treatment initiation and completion rates while reducing behavioral problems and parental stress (Kolko et al., 2014; Oppenheim et al., 2016). These models are associated with higher patient engagement, increased service utilization, and improved clinical outcomes, particularly for attention deficit hyperactivity disorder and depression (Richardson et al., 2014; Chen et al., 2021; McLeigh et al., 2022). Integrated models also enhance resource efficiency by reducing reliance on external referrals and improving care coordination (Rafla-Yuan et al., 2022). Embedding mental health services within primary care has been shown to double the likelihood of receiving guideline-recommended psychotherapy, significantly improving access and service quality (Chen et al., 2021). Beyond improving clinical outcomes, integrated models enhance resource efficiency by reducing reliance on external referrals and streamlining care coordination (Rafla-Yuan et al., 2022).

Policy Reform for Sustainable Integrated Care

This review identified five articles examining policy reforms necessary to sustain and expand integrated care models for youth in foster care. Findings highlight Medicaid reimbursement restrictions as a significant barrier, limiting access to coordinated, high-quality healthcare (Oppenheim et al., 2016). Limited reimbursement for care coordination and team-based services was reported to hinder the scalability of integrated care models. Workforce training and infrastructure development were identified as critical for effective implementation. Findings indicate that expanding provider education in TIC and child welfare policies is necessary to equip healthcare professionals to deliver integrated, multidisciplinary care (Loria et al., 2021). Additionally, the fragmentation between healthcare, social services, and education systems impeded care coordination. Articles emphasized the need for cross-sector collaboration, data sharing, and interagency communication to improve service continuity for youth in foster care (Burke et al., 2015; Lammimen et al., 2020; Rafla-Yuan et al., 2022).

Need for Research

Finally, five articles highlighted significant research gaps in evaluating integrated care models for pediatric and adolescent populations, particularly youth in foster care. Findings indicate a lack of high-quality, longitudinal studies, limiting direct comparisons with traditional pediatric primary care

and obscuring the long-term impact of integrated models (Asarnow et al., 2017; Babajide et al., 2020; Richardson et al., 2017). Most research on integrated care focused on adult populations, with limited studies examining its application in pediatric, adolescent, and young adult populations, especially youth in foster care (McLeigh et al., 2022). Additionally, the literature primarily addresses depression treatment, with few studies evaluating the impact of integrated care on other mental health conditions common among foster youth, such as anxiety, posttraumatic stress disorder, and behavioral disorders (Babajide et al., 2020). Finally, findings also highlight the absence of studies assessing the long-term effects of integrated care on mental health outcomes in children and adolescents, further limiting understanding of its effectiveness in improving developmental trajectories and overall well-being (Asarnow et al., 2017).

DISCUSSION

Findings from this review reinforce the effectiveness of integrated care models in addressing the complex healthcare needs of youth in foster care. By embedding mental health services within primary care, these models improve access, care coordination, and continuity, mitigating the challenges associated with fragmented healthcare, placement instability, and unmet medical needs. Compared to traditional pediatric primary care models, integrated care models can increase treatment initiation, improve service completion rates, and reduce behavioral issues, particularly for high-risk conditions. However, systemic barriers remain despite these benefits, including policy limitations, financial constraints, and workforce shortages.

A key challenge identified in this review is the lack of a standardized definition of integrated care, which complicates evaluation, implementation, and scalability. Additionally, insurance reimbursement restrictions remain a significant financial barrier, limiting provider compensation for care coordination and multidisciplinary, trauma-informed services. Addressing reimbursement gaps is essential to ensuring the sustainability of integrated care models and expanding their reach and effectiveness. Beyond financial barriers, fragmentation between healthcare, social services, and education systems continues to disrupt service continuity. Strengthening partnerships between child welfare agencies, schools, and healthcare providers may further reduce gaps in service delivery and enhance outcomes for youth in foster care.

Despite the growing evidence supporting integrated care, research gaps persist. Most studies focus on depression treatment, leaving critical gaps in understanding how integrated care supports other prevalent mental health conditions. Additionally, few studies evaluate the long-term benefits of integrated care, including its impact on hospitalizations, developmental trajectories, and overall well-being. Future research should examine developmentally tailored care models, assess cost-effectiveness, and explore provider training strategies to enhance trauma-informed, integrated care. Without rigorous economic evaluations, policymakers may hesitate to invest in scaling integrated care for youth in foster care, limiting access to comprehensive, coordinated healthcare services.

LIMITATIONS

The literature identifies key themes in integrated healthcare for vulnerable pediatric populations, particularly youth in foster care, but reveals significant gaps. Research on diversity and culturally responsive care within these models is limited, and few studies focus specifically on youth in foster care. Guidance on implementation is scarce, with only a handful of articles detailing successful integrated care clinics. Most research focused on primary and mental healthcare, with minimal attention to other sectors like spiritual care, dentistry, or legal support. Similarly, studies exploring the use of telehealth to improve access, particularly in rural and underserved areas, are limited. While the literature offers a foundation for exploring integrated care for youth in foster care, many studies are constrained by small sample sizes, and randomized controlled trials assessing long-term outcomes are rare. The field is dominated by observational studies and expert opinions, with inconsistent definitions of "integrated care" and "coordinated care," complicating meaningful comparisons. Understanding and improving care models requires a standardized definition and more rigorous research.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

Integrated care has proven effective in improving healthcare access and adherence to clinical practice guidelines, particularly for vulnerable populations such as youth in foster care. Positive outcomes, including better patient access, higher treatment completion rates, and improved clinical outcomes, reinforce the transformative potential of integrated care models. However, further research is needed to address persistent gaps and challenges and fully explore their efficacy. To promote integrated care in practice, healthcare organizations should prioritize implementing team-based approaches that streamline care delivery and enhance patient engagement. Co-located services or telehealth infrastructure can address geographic and logistical barriers, especially in rural or underserved areas. Policymakers should align reforms with local, state, and regional child welfare policies, incentivizing collaboration and providing sustainable funding mechanisms to support these models. Policy reforms must reflect expert recommendations and address the complex healthcare needs of youth in foster care, including enhanced health surveillance practices. This requires an environment that fosters and incentivizes integrating primary and mental health services through sustainable funding and infrastructure investments. While no universally accepted definition of integrated care exists for pediatric populations, most definitions agree that integrated care involves team-based, collaborative approaches combining various healthcare types, including primary and mental health. To improve practice, clinicians should work within interdisciplinary teams to

break down silos and normalize mental health care, reducing stigma and fostering innovative, collaborative care models.

CONCLUSION

Children, particularly youth in foster care, represent a vulnerable population with often complex healthcare needs. The emerging integrated care model offers a promising approach to transforming healthcare for these groups. This narrative review examined integrated primary and mental healthcare models, focusing on their impact on access and outcomes for youth in foster care compared to traditional pediatric primary care. The review underscores the importance of establishing standardized concepts and measures to develop consistent, effective healthcare delivery frameworks. It also provides a foundation for assessing integrated care resources in a Midwest community, including infrastructure and policy support needs during the planning process. While the literature highlights the feasibility and potential of integrated care to improve access and outcomes, significant gaps remain in understanding its full impact on specific populations like youth in foster care. The findings have implications that extend beyond the Midwest, influencing health, policy, and research across multiple sectors. As the healthcare landscape evolves, proactive engagement with research, policy, and systemic changes is essential to ensure the successful implementation and sustainability of these innovative models, ultimately meeting pediatric populations' diverse and complex needs.

DECLARATION OF GENERATIVE AI AND AI-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this work, the author(s) used Grammarly and ChatGPT to proofread and reduce word count. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

ETHICAL STATEMENT

This original manuscript, a narrative literature review, has not been published or submitted elsewhere and does not involve primary research, human, or animal subjects; thus, ethical approval was not required. Supported by external funding from the Michigan Health Endowment Fund for a community assessment project, the funder had no role in the design, analysis, writing, or submission. The authors declare no conflicts of interest and comply with the *Journal of Pediatric Health Care* submission and copyright transfer policies.

AUTHOR CONTRIBUTIONS

All authors meet the ICMJE criteria for authorship. C.Q., as project lead and grant principal investigator (PI), contributed substantially to the conceptualization, methodology, literature review, and drafting of the manuscript. M.C.M., E.B., M.K., and D.H. significantly contributed to conceptualization, methodology, literature review, thematic analysis, and writing. A.R. critically reviewed the work and provided key revisions to the resubmitted manuscript. All authors reviewed and approved the final manuscript and accept accountability for its accuracy and integrity.

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CONFLICTS OF INTEREST

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REFERENCES

American Academy of Pediatrics, District II, New York State, Task Force on Health Care for Children in Foster Care. (2005). *Fostering health: Health care for children and adolescents in foster care* (2nd ed.). AAP District II. https://www.aap.org/en/patient-care/foster-care/fostering-health-standards-of-care-for-children-in-foster-care/

Asarnow, J. R., Kolko, D. J., Miranda, J., & Kazak, A. E. (2017). The pediatric patient-centered medical home: Innovative models for improving behavioral health. *American Psychologist, 72*(1), 13–27. doi:10.1037/a0040411

Asarnow, J. R., Rozenman, M., Wiblin, J., & Zeltzer, L. (2015). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics, 169*(10), 929–937. doi:10.1001/jamapediatrics.2015.1141

Babajide, A., Ortin, A., Wei, C., Mufson, L., & Duarte, C. S. (2020). Transition cliffs for young adults with anxiety and depression: Is integrated mental health care a solution? *The Journal of Behavioral Health Services & Research, 47*(2), 275–292. doi:10.1007/s11414-019-09670-8

Burke, M., McCauley, H. L., Rackow, A., Orsini, B., Simunovic, B., & Miller, E. (2015). Implementing a coordinated care model for sex trafficked minors in smaller cities. *Journal of Applied Research on Children: Informing Policy for Children at Risk, 6*(1), 7. doi:10.58464/2155-5834.1240

Burkhart, K., Asogwa, K., Muzaffar, N., & Gabriel, M. (2019). Pediatric integrated care models: A systematic review. *Clinical Pediatrics, 59*(2), 148–153. doi:10.1177/0009922819890004

Centers for Disease Control and Prevention (CDC). (2021). *About the CDC-kaiser ACE study*. Violence Prevention Injury Center, CDC. https://www.cdc.gov/violenceprevention/aces/about.html

Chen, H., Upadhyay, N., Lyu, N., & Rowan, P. (2021). Association of primary and behavioral health integrated care upon pediatric mental disorder treatment. *Academic Pediatrics, 21*(7), 1187–1194. doi:10.1016/j.acap.2021.05.021

Clarkson Freeman, P. A. (2014). Prevalence and relationship between adverse childhood experiences and child behavior among young children. *Infant Mental Health Journal, 35*(6), 544–554. doi:10.1002/imhj.21460

Council on Foster Care, Adoption and Kinship Care, Committee on Adolescents, and Council on Early Childhood. (2015). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics, 136*(4), e1131–e1140. doi:10.1542/peds.2015-2655

Duffee, J., Szilagyi, M., Forkey, H., & Kelly, E. T. (2021). Trauma-informed care in child health systems. *Pediatrics, 148*,(2) e2021052579. doi:10.1542/peds.2021-052579

Espeleta, H. C., Bakula, D. M., Sharkey, C. M., Reinink, J., Cherry, A., Lees, J., Shropshire, D., Mullins, L. L., & Gillaspy, S. R. (2020). Adapting pediatric medical homes for children and youth in foster care: Extensions of the American Academy of Pediatrics guidelines. *Clinical Pediatrics, 59*(4–5), 411–420. doi:10.1177/0009922820902438

Greiner, M. V., & Beal, S. J. (2017). Developing a health care system for children in foster care. *Health Promotion Practice, 19*(4), 621–628. doi:10.1177/1524839917730045

Heath, B., Wise Romero, P., & Reynolds, K. (2013). *A standard framework for levels of integrated healthcare*. SAMHSA-HRSA Center for Integrated Health Solutions. http://medicaldentalintegration.org/wp-content/uploads/2017/10/A_Standard_Framework_for_Levels_.pdf

Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics, 139*,(1) e20151175. doi:10.1542/peds.2015-1175

Karatekin, C., Hong, S., Piescher, K., Uecker, J., & McDonald, J. (2014). An evaluation of the effects of an integrated services program for multi-service use families on child welfare and educational outcomes of children. *Children and Youth Services Review, 41*, 16–26. doi:10.1016/j.childyouth.2014.03.008

Keefe, R. J., Van Horne, B. S., Cain, C. M., Budolfson, K., Thompson, R., & Greeley, C. S. (2020). A comparison study of primary care utilization and mental health disorder diagnoses among children in and out of foster care on Medicaid. *Clinical Pediatrics, 59*(3), 252–258. doi:10.1177/0009922819898182

Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics, 133*(4), e981–e992. doi:10.1542/peds.2013-2516

Kolko, D. J., & Perrin, E. (2014). The integration of behavioral health interventions in children's health care: Services, science, and suggestions. *Journal of Clinical Child and Adolescent Psychology, 43*(2), 216–228. doi:10.1080/15374416.2013.862804

Lamminen, L. M., McLeigh, J. D., & Roman, H. K. (2020). Caring for children in child welfare systems: A trauma-informed model of integrated primary care. *Practice Innovations, 5*(1), 55–64. doi:10.1037/pri0000108

Loria, H., McLeigh, J., Craker, K., & Bird, S. (2021). Trauma-informed, integrated primary care: A medical home model for children with prenatal drug exposure who enter foster care. *Children and Youth Services Review, 127*, 106089. doi:10.1016/j.childyouth.2021.106089

Malik, S., Joychan, S., Goslee, J., DiBianco, M., Addesso, L., Hashemi, N., & Nazeer, A. (2022). Integrated mental health in primary care offices. *International Journal of Child & Adolescent Health, 15*(4), 279–292. https://research.ebsco.com/c/6l5vh5/viewer/pdf/tljrt47brv

McLeigh, J. D., Malthaner, L., Winebrenner, C., & Stone, K. E. (2022). Pediatric integrated care in the primary care setting: A scoping review of populations served, models used, and outcomes measured. *Child: Care, Health and Development, 48*(5), 869–879. doi:10.1111/cch.13000

Miller, B. F., Brown Levey, S. M., Payne-Murphy, J. C., & Kwan, B. M. (2014). Outlining the scope of behavioral health practice in integrated primary care: Dispelling the myth of the one-trick mental health pony. *Families, Systems, & Health, 32*(3), 338–343. doi:10.1037/fsh0000070

National Association of Pediatric Nurse Practitioners (NAPNAP) Partners for Vulnerable Youth Alliance for Children in Foster Care. (2023). Position statement on the healthcare and well-being of children and adolescents in foster care. *Journal of Pediatric Health Care, 37*(3), 347–350. doi:10.1016/j.pedhc.2022.12.004

Njoroge, W. F. M., Hostutler, C. A., Schwartz, B. S., & Mautone, J. A. (2016). Integrated behavioral health in pediatric primary care. *Current Psychiatry Reports, 18*(12), 106. doi:10.1007/s11920-016-0745-7

Oppenheim, J., Stewart, W., Zoubak, E., Donato, I., Huang, L., & Hudock, W. (2016). Launching forward: The integration of behavioral health in primary care as a key strategy for promoting young child wellness. *American Journal of Orthopsychiatry, 86*(2), 124–131. doi:10.1037/ort0000149

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ, 372*, n71. doi:10.1136/bmj.n71

Rafla-Yuan, E., Moore, S., Carvente-Martinez, H., Yang, P., Balasuriya, L., Jackson, K., McMickens, C., & Robles-Ramamurthy, B. (2022). Striving for equity in community mental health: Opportunities and challenges for integrating care for BIPOC youth. *Child and Adolescent Psychiatric Clinics of North America, 31*(2), 295–312. doi:10.1016/j.chc.2021.11.007

Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care. *JAMA, 312*(8), 809–816. doi:10.1001/jama.2014.9259

Richardson, L. P., McCarty, C. A., Radovic, A., & Suleiman, A. B. (2017). Research in the integration of behavioral health for adolescents and young adults in primary care settings: A systematic review. *The Journal of Adolescent Health, 60*(3), 261–269. doi:10.1016/j.jadohealth.2016.11.013

Spencer, A. E., Platt, R. E., Bettencourt, A. F., Serhal, E., Burkey, M. D., Sikov, J., Vidal, C., Stratton, J., Polk, S., Jain, S., & Wissow, L. (2019). Implementation of off-site integrated care for children: A scoping review. *Harvard Review of Psychiatry, 27*(6), 342. doi:10.1097/HRP.0000000000000239

Turney, K., & Wildeman, C. (2016). Mental and physical health of children in foster care. *Pediatrics, 138*,(5) e20161118. doi:10.1542/peds.2016-1118