



BHI WORKFLOW GUIDE FOR PEDIATRIC PATIENT CARE

HOW-TO GUIDE

This guide offers actionable, evidence-based best practices on workflow design enabling pediatric primary care physicians and other members of the care team to overcome key barriers to operationalizing integrated behavioral health (BH) care in their practice. This resource is reflective of the generous time and direction provided by numerous workflow design subject matter experts with firsthand experience effectively integrating BH care within practices.



TERMINOLOGY

- When “primary care physician (PCP)” is utilized in this document, it is inclusive of physicians across specialties—including family medicine, internal medicine, pediatrics, and obstetrics and gynecology. While not trained in primary care, non-primary care specialties, such as cardiology, gastroenterology, neurology, and oncology, can also benefit from integrating behavioral health into their practices to support their patients.
- While “patient” will be used throughout, not that this encompasses the families, caregivers and communities that pay an important role in integrated care.
- The term “behavioral health (BH)” is utilized throughout this document to ensure continuity across AMA’s BHI resources. That said, it is important to recognize that the term “mental health (MH)” is also widely used to describe an individual’s emotional, psychological, and social well-being. The term “mental health” is also often the preferred term when in the context of caring for pediatric patients as it is inclusive of the promotion, prevention, early identification, diagnosis and treatment of mental health conditions.



CALLOUT: A developmental approach to child and adolescent mental health care

PCPs who serve children and adolescents have a unique opportunity to promote healthy mental and emotional development and safe, stable, nurturing relationships in families. In pediatric practice, every well visit from age 0-21 years includes routine, age-specific, social-emotional/functional screening as a central process. Therefore, behavioral health integration focuses on promotion, prevention and early identification, as well as diagnosis and treatment.

Designing a BHI workflow



Depending on the practice size, patient population, current staff capabilities, technology, resources, etc., one organization's BHI workflow may look and feel different from another's. Within this resource, there are key considerations, examples, and tools to help teams create a workflow that works best for their practice while maintaining high-quality, equitable care for patients.

To begin crafting a workflow that is efficient and effective, consider the key questions and workflow criteria.

For a basic grounding in potential approaches to behavioral health integration, please see the [BHI Collaborative's BHI Compendium](#).



TIP: Screening guidance for pediatrics is for **every** well-visit, with discussion between the primary care clinician and patient/family and inclusion of the integrated BH clinician, if there are concerns. Staff training would require training on the age-specific screens and when they are used. Clinicians would also need to be trained on interpretation of the screen. For more details, please review the [AAP's Mental Health Tools for Pediatrics](#).

General considerations

Staffing

- ☐ What kind of staff does the practice need?
 - *Tip: Consider clinical staff and administrative staff for daily operations, clinical care, and data/record management, as well as patient demographics, financial considerations, and practice setting. Reference the [BHI Compendium](#) for model considerations.*
- ☐ Are any key roles unfilled? Is additional training needed?
- ☐ Who will verify insurance eligibility and obtain authorization?
- ☐ Who manages the transition between physical and BH care services, if needed?

Training

- ☐ Does staff need to be trained to screen for BH issues? Which staff will introduce the screen to be completed by the patient/caregiver? Is there a script for use by staff to introduce the screen to the patient/family? Who needs to be trained? Who will provide the training?
- ☐ Is training provided on basic phone crisis management, information gathering, and service descriptions? If so, who needs to undergo this training?
- ☐ Is escalation training provided to all staff members?
- ☐ Is training provided on how to code for BHI services?
- ☐ Is mindfulness and compassion training provided to PCPs?
 - *Tip: Trainings are available from The [AMA STEPS Forward® Toolkit on Individual Resilience and Well-Being](#), the [AMA EdHub® module on Building Trust, Enhancing Care](#), and [UMass Chan Medical School Center for Mindfulness](#).*

Handoffs

- ☐ How, and at what frequency, will the staff discuss BH caseloads?
 - *Tip: See the [BH huddle agenda](#) and [BH orientation checklist](#) included at the end of this resource.*
- ☐ What is the process for identifying and planning handoffs when the integrated BH clinician participates in the pre-clinic huddle or pre-visit planning?
- ☐ How will patient updates be communicated to the integrated care team?
- ☐ How is information documented so that it is visible and can be considered by the PCP at patient appointments?

Technology

- ☐ How and under what circumstances will telehealth be used, if at all, to deliver BH care?
- ☐ What other technologies (e.g., a patient intake solution or BH caseload tracker/registry) are needed for seamless BHI, and how can all BHI staff have access to it?
 - *Tip: [The AIMS Caseload Tracker](#) offers two versions to choose from, depending upon practice and connectivity preferences.*
- ☐ Is there a patient portal? What kind of apps, if any, can be recommended to help patients track their BH issues?
- ☐ How does current software meet data and record management needs? Is additional software required?
- ☐ How will the BH clinician document in the record while assuring confidentiality and also documenting their care of the patient?

Setting logistics

- ☐ Where does the patient wait to see a BH clinician on site?
- ☐ How is privacy ensured in this waiting area?
- ☐ What is the plan for room availability if a warm handoff and brief intervention delay turning a room in the schedule?
- ☐ Where does the patient go when connecting with a BH clinician virtually?
- ☐ What kind of privacy protections are required for virtual visits?



Designing a BHI workflow



Billing and coding procedures

- ☐ Are the appropriate [codes](#) available in the EHR system?
- ☐ Does the primary care clinician know how to bill their visit based on time and complexity when it has included conferring with the BH clinician?
- ☐ Are PCBH and CoCM codes available and their use understood?
- ☐ Who manages BHI coding, submission of claims, documentation, and policies?
- ☐ How might on-site IT, billing, and/or coding team members, if available, help in the initial planning to support building a streamlined documentation workflow (e.g., templates, built-in encounter forms with CPT codes to choose from, software needs, etc.)?

Patient communication and feedback

- ☐ How are patients initially informed of the practice's integration of BH care?
 - *Tip: Consider hanging posters in the restroom, break room, and treatment rooms to encourage patients to share any BH concerns they may have with the PCP.*
- ☐ Who is responsible for updating and providing patient-facing information about BHI on an ongoing basis?

Protocols for crises

- ☐ What is the protocol and plan in place to manage a patient in crisis, such as domestic abuse, homicidal ideation, abuse, etc.?
- ☐ What is the protocol and plan in place to manage if more than one patient is in crisis? How is this prioritized? Where do they wait to meet with a BH clinician?
- ☐ What is the protocol and plan in place to manage a patient who is experiencing a crisis due to a [substance use disorder](#)?
- ☐ What is the protocol and plan in place to manage a patient who has been identified as being at a moderate or severe/imminent risk of [suicide](#) (e.g., the patient is not sent home, or left alone in the exam room)?
- ☐ Who is responsible for safety planning for patients at severe/imminent risk of suicide and/or overdose?
- ☐ Has the practice established a relationship and protocol to access a community mobile crisis team (if available)?
- ☐ Who develops and maintains a referral list with contact information for higher-level care?

Patient and staff feedback

- ☐ How is patient and staff feedback collected and used to iterate and improve the BHI workflow?
- ☐ Which members of the staff are providing feedback?
- ☐ Who is responsible for responding to and acting on feedback received?

Identify and engage patients, families, and caregivers

- ☐ How and when will patients complete the initial BH screening?
- ☐ Is staff training required to choose the appropriate screening tools and introduce them to the patient properly to complete them?
- ☐ How are previous psychotropic medication records requested or obtained via a prescription drug monitoring program (PDMP) or pharmacy?
- ☐ Who will identify functional impairments and problematic symptoms?
- ☐ Who will diagnose a BH condition?
- ☐ How is that information shared across the integrated care team?
- ☐ How is the BH clinician engaged and introduced to the patient?
 - *Tip: Refer to the [BH clinician introduction script](#) for guidance.*
- ☐ When is patient consent to meet with a BH clinician, receive a BH assessment, and proceed with treatment requested and obtained?
 - *Note: A written consent is not needed, but verbal consent would be documented in the note.*
- ☐ How will a BH assessment be conducted, and by whom?

Initiate and provide behavioral health care

- ☐ How is education provided to the patient before a treatment/intervention plan is established so they can make an informed decision to engage/provide consent?
- ☐ How is the treatment plan written to reflect the patient's participation in and approval of the planned intervention(s)?
- ☐ If psychotropic medication is deemed clinically appropriate, will the PCP prescribe or refer to a psychiatrist or developmental-behavioral pediatrician to prescribe?
 - *Tip: Refer to the [Psychopharmacology How-To Guide](#) for more detailed information.*



TIP: The AAP has guidance that recommends co-management with a Child & Adolescent Psychiatrist (CAP) or Developmental-Behavioral Pediatrician when moving beyond first-line medications. Also note that pediatricians can use their [Child Psychiatry Access Program](#) (CPAP) (one in every state) to discuss medication for a patient.



Designing a BHI workflow



DESIGNING A BHI WORKFLOW

INTRODUCING THE TEAM

ADDITIONAL GUIDANCE

PRACTICE SPOTLIGHT

Manage treatment plan and track care outcomes

- ☐ How does the integrated care team track and communicate patient strengths, needs, abilities, preferences in treatment, and challenges or barriers to treatment engagement?
- ☐ How are individual care outcomes monitored and recorded to measure progress/improvement?
- ☐ How are measurement-based care tools used to determine intensity of follow-up or to plan for conclusion of treatment around an episode of care?
- ☐ How often and what kind of follow-ups are scheduled (i.e., visits with the PCP or BH clinician)?
- ☐ How are non-adherent or disengaged patients reengaged with the BH treatment plan?

BHI workflow examples

Here are two detailed workflow examples for the Primary Care Behavioral Health model and the Collaborative Care model:

1. [PCBH Workflow Example](#)
2. [CoCM Workflow Example](#)

Please note, the workflow may look different depending on the practice, staffing, and resources; however, the general sequence of actions is often consistent. Feel free to adjust to fit practice needs, workflows, and resources. You can also see related codes in the callout box on the right.



CALLOUT: Related Codes

PCBH

Brief Psychology Codes

- 90832 – 16-37 minutes
- 90834 – 38-52 minutes
 - may often use non-specific Dx codes: F98.9, F93.9, F43.9, Z62.820:

Health Behavior Codes

- 96156 – assessment
- 96158 – intervention, initial 30 minutes

CoCM

Care Management Codes

- 99492 – first 70 minutes of initial month of collaborative care
- 99493 – first 60 minutes of any subsequent months
- 99494 – each additional 30 min in any month

Proactively adjust treatment if patients are not responding

- ☐ How are changes in the treatment plan considered in advance of needing them?
- ☐ How are treatment plan adjustments decided upon with the patient when needed?
- ☐ How are changes in the treatment plan determined, implemented, and communicated across the integrated care team?



TIP: Download the [Workflow Plan](#) to create your own workflow based on your responses above.



Introducing the team



Warm handoffs

When introducing the patient to the integrated care team, a “warm handoff” is best practice, taking place in person and in front of the patient. All members of the integrated care team can give and receive a warm handoff. For example, the PCP can use a warm handoff to present the patient to the BH team member, and the BH team member can provide a warm handoff back to the team. The PCP can also use a warm handoff with schedulers, lab technicians, or staff who assist with referrals.

While tailoring each “warm handoff” is important, there are some general principles for both a warm handoff and the BH team member’s introduction.

Introduction to integrated care team script

The following is a sample script to introduce a patient to the integrated program and member(s) of the integrated care team. It’s recommended not to read this verbatim but rather to make the following points in your own words.

- **Briefly introduce the role of your BH team member:** *“It sounds like you/your child might be having a lot of stress right now. I work with someone who specializes in helping with these issues, and I would like you to speak with them today to better help me help you/your child.”*
 - There should not be a discernable difference in content or tone between a referral to a BH clinician and a referral to a cardiologist.
- **Reinforce the benefits of seeing a specialist:** *“These are the people who have extensive professional training and skills to address this, you/your child deserve the best care.”*
 - Unless a patient has used a diagnostic term themselves (“I feel depressed”; “I had a panic attack”; “I’m addicted”), it is more effective to use general terms like “stress” to refer to BH problems.
- **Recommend having a conversation with the BH team member, be careful not to promise any specific results:** *“I’d recommend having a quick conversation with them and we’ll all partner to find a path forward.”*
- **Provide the patient with any additional brochures or handouts for more information.**
- **If applicable, let them know someone will be following up to schedule an appointment.**



Introducing the team



BH clinician introduction script

The following is a sample script for the BH team member to introduce themselves to the patient. It's recommended not to read this verbatim but rather to make the following points in your own words.

- **Formally introduce your title and licensure:** *"Hi, I am [Insert Name] and a [title] by training, which means I am the kind of doctor/clinician who talks to people to help them learn how to live better and not the kind who needs to see any part of the body or prescribe medications. I'm part of the team working with [PCP Name] to support your health and development. I specialize in [credentials and/or licensure] and I work with [organization if not part of the same practice]."*
- **Open the dialogue about BHI:** *"Here at [clinic name], we find that patients with your symptoms get better faster when we work together as a team with you and your PCP."*
- **Introduce the care team and your role in it:** *"Our team members bring different strengths and experiences, and we work together to offer you a variety of options for managing these symptoms. My role is to work closely with you until you feel a lot better, and I'll be communicating regularly with your PCP to make that happen as soon as possible."*
- **Inform the patient there may be an associated cost:** *"This treatment may have a cost depending on your insurance. To confirm coverage, make sure to check in with your insurance or follow up with our billing department and they can get it sorted for you."*
 - Someone from the practice may also be able to help the patient learn what their copay might be, even coming to the room depending on your practice structure.
- **Address patient privacy:** *"What we discuss here stays between us and the rest of the medical care team, unless there is evidence that you're in danger to yourself or others."*
 - **When working with minors:** *"What is shared between the patient and myself stays between us and the medical care team unless there is a life/death issue or abuse and then by law I would need to report to the appropriate agency."*
 - **When working with adolescents:** *"As part of providing care for teens, I spend some time talking with adolescents one-on-one. What we discuss is private and stays between the teen, me, and other healthcare team members involved in providing care. This confidentiality helps teens feel comfortable talking openly about their health, emotions, relationships, and other concerns. I strongly encourage adolescents to involve their parent or caregiver in important discussions and decisions whenever possible. However, I cannot share details of our conversation without the adolescent's permission. The exceptions are if I believe there is a serious safety concern—such as a risk of harm to themselves or someone else—or if there is suspected abuse or neglect. In those situations, I am required to take steps to keep the adolescent safe and may need to involve the parents, caregivers, or other appropriate agencies."*
 - Parents should also know that confidential adolescent visits and related records may not be accessible to them without the adolescent's consent, consistent with applicable privacy laws and regulations.
- **Obtain verbal consent from the patient to participate in the BHI program:** This may be facilitated by another team member for informed consent—the person facilitating might use language like, *"Consent and privacy promotes your own autonomy which promotes psychological safety."*
- **Document verbal consent in the EHR**



CALLOUT: Mental health services are covered under EPSDT (for 0-21 on Medicaid). Also, with PCBH the brief psychology code is billed with the visit. CoCM codes are specific to CoCM and billed separately from the visit.



WATCH OUT: Pediatricians explain confidentiality for adolescents with adolescent and the family. Pediatricians will see the adolescent alone, and will encourage the adolescent to include their parent in their discussion. They do not divulge the confidential discussion if the adolescent declines, or if it is a safety issue for the adolescent. Note that a parent cannot access the adolescent's medical record.

Additional guidance



BH huddle agenda

Regular team huddles support the building and maintenance of a strong relationship between the physical health and BH teams, one of the keys to an effective integration program. Huddles foster communication and relationship building and reinforce the benefits of an integrated practice.

Here is a list of items that can be included in an integrated care team huddle agenda:

- ☐ Review of patients scheduled for that day, and plan for age-specific screen(s) to be used
- ☐ Identify scheduling opportunities
- ☐ Determine any special patient needs for clinic day
- ☐ Provide relevant updates about patients seen that week
- ☐ Discuss challenging patient cases
- ☐ Review patients experiencing a crisis from last week or in the Emergency Department
- ☐ Surface workflow challenges or other systems-level issues
- ☐ Conduct quality improvement activities
- ☐ Share important reminders about practice changes, policy implementation, or downtimes for the day



CALLOUT: The frequency and length of huddles will depend on team size, available space (if in-person), and resources. Some practices choose to have a short huddle twice daily, before and after the clinic. Others may have longer weekly huddles. Morning huddles and prior day pre-visit planning can help anticipate age-specific screens needed, whether a warm handoff will be likely, etc.

BH orientation checklist

A BHI orientation helps the physical and BH team members build and strengthen relationships and establish trust. A well-designed orientation is a key component of what makes BHI a success. While the BHI orientation may vary in structure and timing depending upon the practice, it's important that team members have some dedicated time together to become familiar with BHI, the BHI workflow, and each other.

Here's an example of a BHI orientation agenda:

KICKOFF & INTRODUCTIONS (10–20 mins.)

- Share agenda and ground rules
- Introduce team members within primary care and BH
- Conduct a team-building activity

ALIGN ON VISION (45 mins.)

- Generate enthusiasm for BHI
 - Consider involving the leadership team, connecting BHI to the practice's goals, sharing a patient story, etc.
- Create a shared version for the integrated care team
 - *Tip: The AMA's [shared vision resource](#) can be used as a guide*

WALK THROUGH THE BHI WORKFLOW (30 mins.)

- Share the established BHI workflow
 - *Tip: Consider sub-dividing groups by roles upon review*
- Define BHI language within the workflow (e.g., any lexicon that may be new or considered vague)
- Edit the BHI workflow based on team feedback and preferences

DEFINE ROLES & RESPONSIBILITIES (15 mins.)

- Clarify roles and responsibilities of the physical and BH team
 - Relate team member expectations to the team's overall vision
- Create team communication guidelines
 - Consider guidelines such as: when in doubt, overcommunicate to your team members, consider all perspectives, take responsibility for being understood, speak up if there are misunderstandings, support one another as part of one BHI team, etc.
- Have physical (clinical and non-clinical) and BH team (if in-house) shadow team members so they get to know practice styles, roles, and responsibilities outside of BHI



Practice Spotlight



Burlington Pediatrics
and Mebane Pediatrics:
Building behavioral health
capacity within the pediatric
medical home

For the team at [Burlington Pediatrics and Mebane Pediatrics in North Carolina](#), improving access to behavioral health care began with a simple but urgent reality: too many children and adolescents were experiencing mental health challenges, while too few behavioral health specialists were available to meet their needs. Long wait times for specialty services, workforce shortages, transportation barriers, and insurance limitations often left families struggling to access timely care. As a pediatric medical home serving a diverse patient population across suburban and rural communities, the practice recognized an opportunity—and responsibility—to address these gaps directly within primary care.

Rather than beginning with a deficit-focused assessment of what was missing, the practice adopted a strengths-based approach to guide its transformation. The team first examined what they already did well. They identified several existing assets, including strong longitudinal relationships with patients and families, established partnerships with schools and community organizations, robust developmental and behavioral health screening processes, and a culture of team-based care. These strengths provided a foundation upon which more comprehensive behavioral health services could be built.

To expand access to mental health support, Burlington Pediatrics and Mebane Pediatrics launched a Collaborative Care Model (CoCM) program. The practice partnered closely with the North Carolina Psychiatry Access Line (NC-PAL), which provided consultation, education, and psychiatric support as the program developed. Through NC-PAL, primary care clinicians gained access to child and adolescent psychiatric expertise that could be incorporated into routine

patient care, helping families receive evidence-based treatment recommendations without the delays often associated with specialty referrals.

The practice also invested heavily in workforce development. Every physician and advanced practice provider completed the REACH Institute's behavioral health mini-fellowship, equipping clinicians with additional skills in the assessment and management of common pediatric behavioral health conditions. This shared training created a common clinical framework across the organization and increased provider confidence in caring for children with anxiety, depression, ADHD, behavioral concerns, and other common mental health conditions.

As the program matured, Burlington Pediatrics and Mebane Pediatrics expanded beyond psychiatric consultation and medication management to offer Primary Care Behavioral Health (PCBH) services, including problem-based, brief focused behavioral interventions within the medical home. Integrated behavioral health clinicians became embedded members of the care team, providing evidence-based interventions targeted to specific concerns such as anxiety, emotional regulation, sleep difficulties, school avoidance, parent-child conflict, adjustment challenges, and behavioral concerns. These brief interventions allowed families to receive support quickly, often at the point of care through warm hand-offs, while maintaining continuity with their primary care team.

The practice also recognized that improving access alone was not sufficient. To ensure services reached all patients, the organization incorporated a focus on enabling optimal health for everyone into its behavioral health initiatives. Through ongoing quality improvement projects, the team routinely evaluates screening completion rates, referral patterns, engagement in care, and clinical outcomes across different patient populations. These efforts help identify disparities and inform workflow changes designed to reduce barriers to care. By using data to guide improvement, the practice seeks to ensure that every child—regardless of insurance status, race, ethnicity, language, or socioeconomic circumstances—has an opportunity to receive high-quality behavioral health support.

Today, integrated behavioral health has become an essential component of the pediatric medical home at Burlington Pediatrics and Mebane Pediatrics. Through strategic partnerships, clinician training, team-based care, and continuous quality improvement, the practice has expanded its capacity to address behavioral health needs to deliver whole-person care. Their experience demonstrates how pediatric practices can leverage existing strengths to create sustainable, equitable behavioral health services that improve outcomes for children and families.

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