

Why Participate in the BAN Learning Health Network

Frequently Asked Questions for Prospective Clinical Sites

MISSION *“To radically improve the health and well-being of people with bipolar disorder.”*

VISION *“A reimagined system of patients, families, clinicians, and researchers working together to try new ideas, learn from collective knowledge, and continuously advance our mission.”*

Answers for clinical sites considering membership in the BAN Learning Health Network.

- **Now recruiting.** BAN is currently accepting applications from a new cohort of clinical sites.
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Q1. What is the Bipolar Action Network, and what problem is it solving?

Outcomes in bipolar disorder have not improved in twenty years — not for lack of effective treatments, but because each site has been left to determine what works largely on its own, with no systematic way to compare approaches across institutions. BAN was created to close that gap: it is the first learning health network of its kind for bipolar disorder, designed to convert fragmented, trial-and-error care into a system that learns continuously, for the more than 7 million Americans affected by the condition.

This work is operationalized through a shared Data Registry that applies the same outcome measures across every site, enabling real-time tracking and comparison. The approach is yielding results: five of nine early projects demonstrated measurable improvement before the full system was complete. Patients and families have been full partners from the outset, shaping network governance rather than simply providing feedback.

Q2. Who leads BAN, and who's in the network?

BAN is led by Dr. Andrew Nierenberg (Massachusetts General Hospital), an authority on bipolar disorder, and Dr. Peter Margolis (Stanford University), an authority on learning health networks — together with a team of experts in learning health network implementation: Karen Baldoza, Dr. Rachael Fleurence, Dr. Bo Kim, and Dr. Gareth Perry. Both lead investigators have long argued that serious mental illness warrants the same rigorous, data-driven systems of care that have improved outcomes in other chronic diseases.

Nine health systems have already joined, alongside dozens of patients, family members, and other experts by experience — people who live with bipolar disorder — who help shape the network's direction from within:

- Massachusetts General Hospital (MGH)
- Indiana University Health and School of Medicine
- Cincinnati Children's Hospital Medical Center
- Northwestern University
- Virginia Commonwealth University
- University of Cincinnati College of Medicine
- Eliot Community Human Services
- Huntsman Mental Health Institute and Pediatrics
- Cambridge Health Alliance

Each of these sites once faced the same choice your leadership is weighing now: continue independently or join this collaborative effort.

Q3. Has this approach worked for other diseases?

Yes. Learning health networks have a substantial track record outside psychiatry. The National Pediatric Cardiology Quality Improvement Collaborative, spanning 95% of the U.S. population of infants with hypoplastic left heart syndrome, achieved a 40% reduction in mortality. ImproveCareNow, a network of more than 100 care centers serving

over 35,000 children with inflammatory bowel disease — more than 65% of all U.S. pediatric IBD patients — raised remission rates from 60% to 83%. Cincinnati's All Children Thrive Network reduced hospital bed-days by 18% for 8,800 children in the city's three lowest-income neighborhoods.

BAN applies this same learning-network architecture to bipolar disorder for the first time. The infrastructure and methodology are proven; bipolar disorder is the next application.

Q4. Why should my site join?

Solving bipolar disorder care independently carries a real cost: testing changes without knowing whether a peer institution has already identified a better — or worse — approach. BAN eliminates that cost. Sites gain visibility into what works across a network of peer institutions using common measures and can adopt a tested portfolio of system changes rather than developing one independently.

Because BAN is the first network of its kind for bipolar disorder, early participation means shaping the field's standards for bipolar disorder care, not simply adopting them.

Q5. What's in it for my site?

Membership is a two-way partnership: the network invests in your site's capacity to improve, and your site's contributions strengthen the network in return. Specifically:

- **Established improvement infrastructure.** A ready-made portfolio of proven improvements in screening, treatment, care coordination, and patient partnership, supported by structured QI training and ongoing coaching from network experts.
- **Real-time outcomes data.** Shared access to a Data Registry and benchmarked dashboards tracking outcomes at every site, plus automated reports supporting population management and visit preparation.
- **Equitable governance.** An equal vote on research priorities and data-sharing policy regardless of membership tier, and transparent, contribution-based compensation for trial participation, using a consistent formula across all sites.
- **Revenue optimization.** Access to consulting on newly approved bipolar-specific CPT codes and billing structures, to help your site increase revenue while improving structured care.
- **Research access.** Participate in — and help co-lead — BAN-coordinated clinical trials, real-world effectiveness studies, and pragmatic studies. Shared infrastructure reduces the burden of multisite research, and member sites are well positioned for competitive NIH, PCORI, foundation, and industry-sponsored funding.
- **National visibility.** Recognition as a founding member of the first learning health network for bipolar disorder, strengthening your site's national profile with leadership, trainees, and prospective funders.
- **Experts by experience, done right.** Structured coaching on authentically partnering with people who live with bipolar disorder — from advisory councils to care design — drawing on practices already in place across the network.
- **Sustained collaboration.** Monthly network calls, biannual conferences, peer coaching, and shared best-practice guides.

Q6. What's expected of my site?

Membership commitments, corresponding to the benefits described above, include:

- **Leadership and staffing.** Senior leadership committed to improving care for all patients with bipolar disorder, not a pilot cohort alone, supported by a dedicated team — a physician or mental health leader, administrative support, and a lead able to commit 4–6 hours per month to network meetings and activities.
- **Integrated care delivery.** Coordination across mental health, primary care, emergency medicine, hospital, and community care as a single system, with billing codes in place to support structured bipolar care.
- **Data sharing and compliance.** Willingness to share data and outcome measures openly with the network, formalized through a Participation and Data Use Agreement (PDUA) as part of onboarding, alongside IRB

approval — BAN uses a single-IRB model, with sites ceding to the Mass General Brigham IRB — followed by ongoing data submission to the registry.

- **Knowledge sharing.** Contributing a tool, protocol, or lesson learned to the network every six months.

Q7. How is BAN sustained, and what opportunities does that create for my site?

Membership dues are one component of BAN's funding model. The network also builds long-term capacity through philanthropic and industry partnerships, including the funding that supports the scholarship program described later in this document.

These partnerships also create opportunities for member sites, including participation in clinical trials coordinated by BAN and in real-world evidence (RWE) studies using the network's shared Data Registry. Trial participation is compensated according to site contribution, using a consistent formula across the network (see Q5).

Research priorities and governance remain with the network's members and patient partners, not its funders; policies on data use, research participation, and consent are co-developed with the network community.

Q8. What does membership cost, and which tier is my site?

Membership dues are based on the size of your behavioral health department rather than total organizational revenue, across three tiers:

	Anchor Member \$72,500 / year	Network Member \$35,000 / year	Community Member \$15,000 / year
Eligibility	Behavioral health dept. revenue over \$100M — large academic medical centers, integrated systems	Behavioral health dept. revenue \$25M–\$100M — mid-size academic medical centers, regional systems	Behavioral health dept. revenue under \$25M — community health centers (FQHCs), community psychiatry, safety-net clinics
Scholarship	Not applicable	Exceptional cases only, with demonstrated need	Presumptively eligible, subject to annual need review — sites pay the \$15,000 dues; a philanthropic scholarship fund covers the remainder of standard dues for qualifying sites

Q9. Is scholarship support available?

Yes. The scholarship is core infrastructure rather than a supplementary offering: it enables community health centers, safety-net clinics, and community psychiatry programs — and the patients most underrepresented in bipolar research — to participate fully in the network.

Community Member sites pay the standard \$15,000 dues; scholarship funds — drawn from a dedicated philanthropic fund — cover the remainder of what a comparable Anchor or Network site would contribute, so the network is fully resourced without shifting cost onto the sites least able to pay. Eligibility considers each site's overall financial capacity, not only behavioral health department revenue, so scholarship dollars go to the sites that most need them; eligibility is reviewed annually, and awards last three years with the option to renew. Scholarship sites make the same investment as other members in staff time, data systems, and clinical practice changes — only dues are affected.

Q10. What's the timeline, and how do we apply?

Key dates:

- Submit [a one-page letter of interest](#) by November 1, 2026.
- Invitations to join are sent by BAN — December 1, 2026.
- Onboarding begins as soon as contracts are signed.

The letter of interest should address: organizational profile and patient volume; leadership sponsor and team lead; readiness across departments; anticipated tier and scholarship interest; rationale for joining; and a primary contact. (See the full letter-of-interest guidance on this page.)

Q11. Who do we contact with questions?

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LEARN MORE

- [BAN Annual Report](#)
- Nierenberg AA, Margolis P, Strakowski S, Trivedi M, Yatham LN. [A Bipolar Learning Health Network: An innovation whose time has come](#). *Bipolar Disorders*. 2023;25(3):177–180.
- Madara JL, Miyamoto S, Dowdy SC, Greene SM, Tarrant J, Margolis PA. [Transforming Health Care — Shared Commitments for a Learning Health System](#). *N Engl J Med*. 2025;393(2):192–197.