outcome referrals

EXECUTIVE BUYER'S GUIDE & SELECTION RUBRIC

Choosing the Right Behavioral Health Outcome Tool

What Do You Actually Need It to Do? An 11-Point Diagnostic Framework for Health Plans, Systems & Providers

Behavioral health leaders everywhere agree that measurement matters. Yet across health plans, hospital systems, and provider networks, **millions of dollars and thousands of clinical hours are wasted every year** on outcome tools that frustrate patients, burden clinicians, and produce zero measurable improvement in care.

The problem isn't a lack of effort—it's a **mismatch between the tool and the job**. You wouldn't use a bathroom scale to diagnose a fever, and you can't use a single-disorder checklist to run a value-based network, predict hospitalizations, or prove health equity.

Behavioral Health outcome measures are chosen to fill one or more roles.

Check your organization's need(s) below and see what tools rise to the top:

Direct Patient Care	Care Delivery & Risk Management	System, Financial & Compliance
☐ Engage and empower patients	☐ Care coordination	☐ Accountability
☐ Screening	☐ Prevent crises and high-cost care	☐ Reward value / VBC
☐ Measure progress (patient, system, research)	☐ Fill gaps and resolve system disparities	☐ Requirement checkboxes
☐ Course corrections		
☐ Drive better care decisions		

DIAGNOSTIC TAKEAWAY

If you only checked one box at the very bottom of the list, a basic public-domain screener might get you by. If you checked more than two—especially across clinical care, risk management, and value-based payment—**you need a multidimensional outcome engine.** Here is what happens when you match each of these 11 needs to the right instrument—and why the **Treatment Outcome Package © (TOP)** consistently rises to the top.

Why does TOP **rise above the rest?** Over four decades, TOP has outperformed all other behavioral health tools in accuracy and predictive validity. However, if one statistic stands out, it is this: **with TOP, 96% of providers are statistically superior to their peers in treating at least one major behavioral health issue—15x better than any other tool.** With that insight in hand, nearly every provider has distinct clinical value, and every network can be optimized.

DOMAIN 01 • CLINICAL ENGAGEMENT & PRECISION

Direct Patient Care

01 Engage and Empower Patients

Listen first. Engaging your consumers, members, and patients starts with listening to their needs and concerns. If your outcome assessment doesn't scream, *"I'm finally in the right place!"*, you have lost an opportunity.

If a homeowner has a water leak and you show up carrying only a hammer, you will struggle to convince them you can fix their problem. Similarly, if you lead every behavioral health engagement with a narrow screener like the PHQ-9, you send an unintended message: *your other issues are less important.*

Put the patient in the driver's seat. Imagine handing a patient a comprehensive—yet brief—outcome assessment and saying: *"Filling this out helps us understand what we should work on together. When you complete it again next month, it will show both of us what is improving and where our focus should shift."* That puts the patient in control. You are measuring your clinical success through their self-assessment. They become an empowered VIP—right where they belong.

> **FIELD EVIDENCE • BLUE CROSS BLUE SHIELD OF MASSACHUSETTS**
>
> When Blue Cross Blue Shield of Massachusetts selected its statewide outcome tool, it conducted blinded focus groups showing patients and providers several leading assessments. Hands down, one tool rose to the TOP. As participants noted: ***"This one shows they care about all of me."***

02 Screening

If you only screen for one or two conditions, you telegraph what you care about—and what you plan to ignore. Worse, relying on a tool with a high false-positive rate (such as the PHQ-9, which can yield roughly 65% false positives in primary care screening) leaves clinicians with an awkward conversation: *"You screened positive for major depression, so let's discuss treatment—even though there is only a 35% chance you actually have it."*

Only one tool was developed by factor-analyzing nearly every symptom in the diagnostic manual and replicating those findings across approximately one million patients at all levels of care. **TOP takes about the same time as administering the PHQ-9 and GAD-7 together, yet it delivers validated screenings across 12 distinct behavioral health and well-being dimensions simultaneously.**

03 Measuring Progress

For the patient, for the system, and for research.

Whether you are tracking progress for a single patient, an entire health system, or clinical research, your tool must maximize **reliable change**. Most standard tools—including the PHQ-9 and GAD-7—have a remarkably narrow window of average patient improvement (typically just 5 to 7 points). When the scoring window is that compressed, almost every provider and health system looks average.

- **If your goal is to blend in:** Narrow scales work fine if you are content with every provider looking average.
- **If your goal is clinical excellence:** To identify and reward service excellence, strengthen the therapeutic alliance, and prove to patients they are in good hands, you need a far more sensitive, multidimensional instrument.

04 Course Corrections

"Measurement-informed care" is often mislabeled across the industry due to imprecise literature reviews. Nearly all the positive research behind routine outcome monitoring is actually **course correction research**.

- **Data collection alone isn't enough:** Following her seminal *JAMA Psychiatry* work, Dr. Cara Lewis published a critical evaluation of the PHQ-9 where every standard box was checked—data was collected, providers reviewed it, patients saw their scores, and treatment implications were discussed. The result? **Zero impact on clinical outcomes.**
- **Automated alerts drive real change:** Outcome data improves care almost exclusively when paired with automated course-correction guidance—such as alerting a primary care physician that a current medication dosage isn't working. Similarly, Dr. Michael Lambert's landmark research demonstrated that flagging non-responders early and providing action-oriented clinical checklists can **reduce treatment non-response by up to 90%.**

Only a select few platforms—including **TOP** and the **OQ**—have these real-time course-correction alerts built directly into clinical workflows.

05 Drive Better Care Decisions

The right outcome data doesn't just measure care; it actively steers patients toward better results:

- **Preventing avoidable hospitalizations:** By linking TOP data with commercial and Medicaid claims, health plans like Blue Cross Blue Shield of Massachusetts can predict near-future psychiatric hospitalizations—allowing them to flex benefits early and prevent high-cost crises.
- **Matching levels of care:** Even in complex environments like child welfare systems in Iowa and North Carolina, TOP helps identify the exact level of care where a youth has a **4x better chance** of achieving above-average outcomes.
- **Doubling recovery rates through provider matching:** In a landmark PCORI-funded study published in *JAMA Psychiatry*, TOP was used to match (**TOP Match™**) patients with a short list of available providers proven to treat their specific symptom profile. The result? **Double the average clinical outcomes**, returning the average consumer to full, sustained recovery a full year after treatment.

> **REAL-WORLD IMPACT • OPTUM BEHAVIORAL CARE**
>
> Optum Behavioral Care knew they were delivering extraordinary value to both patients and staff when clinicians began volunteering to work later into the evening for **TOP Match™** referrals—patients with whom they knew they were highly likely to succeed. At the same time, new patients started calling in and asking specifically to be "TOP Matched," having heard about the life-changing results directly from their neighbors.

While organizations using the PHQ-9 or similar narrow scales for care navigation consistently report *"no effect on outcomes,"* multidimensional, risk-adjusted data makes game-changing care decisions possible.

DOMAIN 02 • NETWORK COORDINATION, SAFETY & EQUITY

Care Delivery & Risk Management

06 Care Coordination

Create a shared language.

Healthcare is notoriously fragmented. A primary care doctor looks at lab values, a psychiatrist tracks medication side effects, a therapist focuses on emotional processing, and a caseworker worries about housing or school stability. When everyone uses different tools—or relies on unstructured clinical notes—critical signals get lost in translation.

Relying on narrow symptom checklists leaves care teams guessing about the bigger picture. You need a universal dashboard that everyone on the care team can understand at a glance. That is exactly what **Atrius Health** built, creating a unified dashboard based on TOP results that every caregiver could see.

- **Align multidisciplinary teams:** Standardized, multidimensional profiles give therapists, prescribers, primary care physicians, and family members a single, objective baseline to rally around.
- **Streamline transitions of care:** When a patient steps down from inpatient hospitalization to outpatient therapy, clean longitudinal data ensures the receiving provider knows immediately what improved and what risks remain.

> **PATIENT OWNERSHIP • ATRIUS HEALTH**
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> Atrius knew they had truly met their goal when patients began reporting that they had **posted their personal TOP mental well-being dashboard right on their refrigerators.**

07 Prevent Crises and High-Cost Care

Stop playing defense.

In most behavioral health systems, we only find out a patient is in crisis when they show up in the emergency room, relapse, or stop coming to appointments altogether. By then, the human toll is devastating—and the financial cost has skyrocketed.

Narrow screeners miss the early warning signs because crises rarely happen in a vacuum. A patient's depression score might look flat, while their sleep is collapsing, their substance use is creeping up, and their work life is unraveling.

The untold secret in behavioral health is that most patients *want* to tell their story and share their full distress—if someone just dares to ask and listen. A comprehensive outcome tool opens that door. More often than not, a patient in acute distress will reveal hidden thoughts and budding risks for the very first time, giving providers the window they need to act early.

- **Spot the storm before it hits:** Tracking 12 clinical and functional dimensions simultaneously uncovers subtle patterns of deterioration weeks before an acute emergency occurs.
- **Protect lives and budgets:** High predictive validity—combined with built-in risk stratification for suicidality, violence, and psychosis—allows care managers to intervene early, flex outpatient support, and prevent avoidable psychiatric hospitalizations.

WHY LISTENING SAVES LIVES • THE BRIEN CENTER

In the late 1990s, when TOP was being deployed across nearly all community mental health centers in Massachusetts, Ray Brien—CEO of what is now the Brien Center—called to tell us the tool had just saved a life. A mother had indicated on her TOP assessment that she was having thoughts of harming someone *"all of the time."* The student intern managing the case had overlooked the red flag, but a clinical supervisor spotted the alert immediately and stepped in to ask about it. Emergency responders were dispatched and arrived at the home just in time to intervene and protect her newborn before a tragedy occurred. It was the first of thousands of stories proving a simple truth: **asking the right questions—and truly listening—saves lives.**

08 Fill Gaps and Resolve System Disparities

You can't fix what you can't see.

Health equity isn't just a mission statement; it is a measurable clinical standard. Yet most health systems fly blind when it comes to disparities because raw symptom scores tell an incomplete story. Published research demonstrates that **TOP Match™** directly helps alleviate these disparities—delivering its most pronounced clinical benefits to individuals in the greatest need and those who self-identify as belonging to a minority group.

If one clinic has lower raw improvement scores than another, is it delivering worse care—or is it serving a higher-acuity population facing severe social and economic barriers? Without proper risk adjustment, systems either ignore hidden inequities or unfairly penalize safety-net providers.

- **Separate patient acuity from provider performance:** Validated demographic and case-mix adjustments level the playing field, revealing how well programs actually perform across different racial, socioeconomic, and geographic groups.
- **Target resources where they matter most:** Aggregated population data exposes exact service gaps—such as specific neighborhoods or demographics struggling with engagement or recovery—so leaders can deploy targeted support rather than guessing.

In fact, TOP's case-mix variables and risk adjustment account for an industry-leading **53% of outcome variance** based solely on the initial assessment. In other words, the majority of where a patient is headed is visible on day one—allowing systems to match them immediately to the right level of care, and the right provider at that level, before disparities take root.

DOMAIN 03 • ACCOUNTABILITY, VALUE-BASED PAYMENT & REGULATION

System, Financial & Compliance Drivers

09 Accountability

Move beyond counting visits.

For decades, behavioral health accountability meant measuring inputs: *Did the patient show up? Was the note signed on time? How many sessions were billed?* Measuring activity tells you how busy your network is, not whether anyone is actually getting better.

When systems try to measure outcomes using basic tools like the PHQ-9, providers quickly learn how to game the numbers—or avoid taking complex patients altogether so their averages don't drop.

- **Measure true clinical value:** Risk-adjusted benchmarking evaluates clinicians and programs on the actual improvement they deliver relative to a patient's starting complexity.
- **Build a culture of excellence:** Transparent, fair performance data empowers clinical supervisors to coach struggling providers while celebrating and learning from top performers.

10 Reward Value / VBC

Pay for recovery, not just volume.

If a tool cannot identify the unique skills of behavioral health providers, it cannot serve as a Value-Based Care (VBC) engine. You could theoretically reward therapists based on patient BMI scores, too—but it is the wrong tool for the job. Similarly, research has shown that the PHQ-9 is unable to distinguish between individual providers' outcomes, rendering it little more than **an expensive paperweight covering a compliance checkbox.**

Value-Based Care has transformed physical medicine, yet behavioral health has lagged behind for one simple reason: payers and providers lacked a trustworthy way to price and verify clinical success. You cannot build a credible VBC contract on a 9-question depression screener with a 5-point improvement window. Payers need proof that better behavioral health outcomes translate into healthier members and lower total medical costs.

- **Steer members to proven quality:** Verified outcome data allows health plans and employers to reward high-performing clinicians with enhanced reimbursement rates, shared savings, and priority referrals.
- **Prove medical cost offset:** Linking multidimensional outcome improvements to medical claims demonstrates how effective behavioral health care directly reduces ER visits, chronic disease complications, and total cost of care.

11 Requirement Checkboxes

Turn compliance from a burden into a byproduct.

Clinicians didn't enter the field to become data-entry clerks. Yet every year, accreditation bodies, state regulators, and health plans pile on new reporting mandates—forcing patients to fill out redundant forms and burning out frontline staff.

Checking regulatory boxes shouldn't require sacrificing clinical depth. When you choose a comprehensive outcome engine from the start, compliance happens automatically in the background.

- **One assessment, multiple mandates:** Crosswalked scoring alongside standardized documentation satisfies HEDIS, CMS, accreditation, and billing requirements without subjecting patients to survey fatigue.
- **Future-proof your organization:** Instead of scrambling every time a payer updates its quality metrics, a multidimensional baseline already captures the clinical and functional data regulators will ask for next year.

Finally, if checking a regulatory box is your main reason for measuring outcomes right now, **TOP automatically generates equivalent PHQ scores. Check your box—and start doing something meaningful today.**

Ready to See What Rises to the TOP?

If you checked multiple boxes on this list, you don't need to stitch together a dozen disconnected questionnaires, overwhelm your clinicians with redundant paperwork, or settle for flat metrics that fail to move the needle on patient recovery. Whether your priority is empowering patients in the therapy room, matching members to high-performing providers with TOP Match™, or building a defensible Value-Based Care network, Outcome Referrals delivers the only validated, case-mix-adjusted engine built to handle every job on your list.

- **See it in action:** Schedule a customized walkthrough of the TOP platform and TOP Match™ predictive routing as seen in the NIH-funded ExpressAccessNetwork.com – the world's first, neutral, scientific referral layer for healthcare.
- **Review the evidence:** Request our peer-reviewed research packet detailing outcomes across commercial plans, Medicaid, and child welfare.
- **Test the difference:** Ask for a sample longitudinal dashboard to see the exact visual report patients post on their refrigerators.

Contact Outcome Referrals today at info@outcomereferrals.com to turn outcome measurement from an administrative chore into your organization's greatest clinical and financial advantage.

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