

Northwestern Medicine West Health Accelerator

LEARNINGS AND IMPACT FROM IMPLEMENTING THE COLLABORATIVE CARE MODEL ACROSS A HEALTH SYSTEM

A MODEL THAT IMPROVES ACCESS TO EFFECTIVE MENTAL HEALTH CARE

Americans' self-reported mental health ratings have dropped to a six-year low, according to a recent West Health-Gallup Center on Healthcare in America survey.¹ More than 1 in 5 U.S. adults lives with a mental health or substance use condition, and half go without adequate treatment.² The Collaborative Care Model (CoCM) integrates mental health treatment into primary care through a team that includes a primary care provider (PCP), a behavioral health care manager ("care manager"), and a psychiatric consultant. The team delivers coordinated, evidence-based, time-limited care for common chronic conditions such as depression and anxiety. CoCM lets one psychiatric consultant support up to eight times as many patients as they could see individually,³ is proven effective at reducing mental health symptoms across diverse patient populations,⁴ and can save up to \$6 in long-term health care costs for every \$1 invested.⁵

Launched in fall 2024, the Northwestern Medicine West Health Accelerator supports and studies the scale-up of CoCM across Northwestern Medicine's adult primary care network. The Accelerator is designed to create practical, scalable solutions to reduce barriers to implementing CoCM at Northwestern Medicine and across the nation.

GROWING OUR REACH (as of October 2026)

80+	Primary care clinics offering CoCM — the entire Northwestern Medicine adult primary care network
11,500+	Patient referrals into the program since launch
4,700+	Patients enrolled in the program since launch
85%	Of adult primary care patients screened for depression
7%	Of claims denied by insurers, down from 17% a year ago
87%	Of patients pay less than \$50 per month

"I am incredibly grateful, just thinking about where I was then to where I am now, it's incredible."

— A Northwestern Medicine Collaborative Care Patient

WHAT WE HEARD FROM CLINICIANS

THEMES

Mental Health Needs Are Growing in Primary Care: PCPs described mental health concerns as common, high priority, and increasingly acute, with long waits for psychiatry and therapy.

Care Between Visits: PCPs valued care manager outreach, symptom monitoring, and follow-up between primary care visits. This is the preventive and ongoing care management that CoCM payment is meant to support.

Psychiatric Consultation is the Backbone: Care managers described psychiatric consultants as central to patient care and as mentors who strengthen their clinical skills. That makes consultant time a core part of what practices must fund and staff.

PCP/CARE MANAGER PERSPECTIVES

"I've practiced 30 years, and I think the mental health needs are even more now than previously and even more acute than previously." —PCP

"I love the fact that somebody's checking in with my patients when my staff and I can't do it." —PCP

"We can't do our job without [consulting psychiatrists]. It's very much hand in hand." —Care Manager

- 1 Patients want their PCPs to ask about and treat their mental health.⁶
- 2 Medicare already pays for CoCM, yet fewer than 1% of U.S. primary care sites bill for it today.⁷
- 3 Providers want to deliver this care, but uneven payment and complex billing requirements have gotten in the way.

KEY BARRIERS TO ADOPTION AND IMPLEMENTATION

1. **Upfront costs:** Practices must fund care managers, psychiatric consultation, and patient tracking system builds before they can bill for CoCM.
2. **Administrative burden:** Red tape around consent, diagnosis, and billing makes it hard to enroll patients in CoCM.
3. **Patient cost sharing:** Monthly patient costs deter the people who most need preventive care.
4. **Uneven coverage and reimbursement:** State Medicaid coverage, payment, and care manager requirements vary widely, making it even more difficult to implement CoCM in many regions.

WHAT YOU CAN DO

West Health and the Meadows Mental Health Policy Institute are committed to taking what we learn through the Accelerator to inform policy strategies that reduce these barriers for other programs to start and scale CoCM.

BARRIER	POLICY PRIORITY
Upfront costs	Increase reimbursement during startup Starting a CoCM program requires investment in staffing, registry builds, and technical assistance before billing begins. The Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act would temporarily increase Medicare payment for each CoCM code by at least 75% in the first year, 50% in the second, and 25% in the third, helping practices cover these upfront costs.
Administrative burden	Remove duplicate consent and prior-diagnosis rules, and simplify billing Requiring the referring provider to document verbal consent, including a cost-sharing discussion, adds burden that other care management services don't carry. Requiring a prior mental health diagnosis before enrollment conflicts with CoCM's purpose as an early identification and treatment model. Calendar-month billing periods also cut off care that spans a month boundary, and rolling 30-day periods would fix this.
Patient cost sharing	Reduce cost barriers for patients Because CoCM is billed monthly, patients can face cost sharing every month of treatment, which deters people from seeking care. Two changes would ease this: reducing or waiving cost sharing on the CoCM codes, and adding CoCM to the IRS preventive care safe harbor for depression so high-deductible plans can cover it before the deductible.
Uneven coverage & reimbursement	At the state level, align Medicaid CoCM coverage and requirements with Medicare Some states don't cover CoCM in both fee-for-service and managed care, pay below Medicare, or add requirements Medicare doesn't impose. These include attestation forms, prior authorization, and care manager licensure mandates. Such requirements delay enrollment and deter smaller clinics. Three steps would support more consistent adoption across states: covering CoCM at no less than Medicare rates, removing state-specific requirements, and using standard care manager competency expectations.

¹ Jones, J. M. (2025, December 18). *U.S. mental health ratings continue to worsen*. Gallup. <https://news.gallup.com/poll/700079/mental-health-ratings-continue-worsen.aspx>

² National Institute of Mental Health. (2024, September). *Mental illness*. <https://www.nimh.nih.gov/health/statistics/mental-illness>

³ Carlo, A. D., et al. (2024). Extending the clinical impact of behavioral health prescribing clinicians using the Collaborative Care Model (CoCM). *Journal of General Internal Medicine*, 39(8), 1525–1527. <https://doi.org/10.1007/s11606-024-08649-2>

⁴ Archer, J., et al. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, (10), CD006525. <https://doi.org/10.1002/14651858.CD006525.pub2>

⁵ Unützer, J., et al. (2008). Long-term cost effects of collaborative care for late-life depression. *American Journal of Managed Care*, 14(2), 95–100. <https://pubmed.ncbi.nlm.nih.gov/18269305/>

⁶ Fioroni, S., & Witters, D. (2024, November 20). *Most Americans want doctors to ask about mental health*. Gallup. <https://news.gallup.com/poll/653300/americans-doctors-ask-mental-health.aspx>

⁷ Davenport, S., Mager, M., & Darby, B. (2025, May). *Trends in adoption of the Collaborative Care Model: Analysis of variation by payer and region, 2018–2023* [Report commissioned by the Meadows Mental Health Policy Institute]. Milliman. <https://mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf>