NATIONAL ALLIANCE FOR CAREGIVING

LIVE WEBINAR

From Insights to Action: Practical Methods for Integrating Caregivers into Care Delivery

MAY 27, 2026

1:00PM - 2:00PM ET

Agenda

About NAC

The Big Picture: Why Caregiver Integration Matters

Mayo Clinic Inpatient Caregiver Program

UCSF Caregiver Training Services Codes Resources

Michigan Caregiver Navigation Toolkit

Q&A

About NAC

Established in 1996, the National Alliance for Caregiving (NAC) is a system change organization transforming how we value the **63 million family caregivers** through **research**, **advocacy**, and **narrative change**.

CANCER CAREGIVING COLLABORATIVE

Dedicated to championing systemic change that ensures cancer caregivers receive the equitable support, training, and financial relief they deserve.

TRANSPLANT CAREGIVING COLLABORATIVE

Focuses on enhancing the recognition, inclusion, and support of family caregivers within the transplant system.

Key Insight

Caregiver Recognition & Support

33%

Percentage of family caregivers who want policies that require health care professionals to assess their needs to care for their recipients

Complexity & Intensity of Caregiver Demands

Family caregivers are essential for patient safety

- **7 in 10** monitor the severity of their care recipient's health condition
- **55%** routinely take on **medical and nursing** responsibilities
- **Yet, only 22% report receiving training**
- 57% report being in an intense caregiving situation

This is the core challenge: high responsibility, inconsistent or no support

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"It's like being thrown into a job you didn't apply for with no training, ***no pay, no support, and no days off."***

- R.H.

Source: Caring without a Roadmap: Insights from Family Caregivers

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Impact on Caregiver Well-Being

Health Status

- 1 in 5 caregivers report their own health as fair or poor

Physical Health

- 45% experience moderate to high physical strain from caregiving duties

Emotional Strain

- 64% report moderate to high emotional strain

The strain is real, widespread, and preventable, if health systems treat caregivers as partners, not bystanders.

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"When my son went to college across the country, I was remotely caring for a college kid with special needs, and it made me feel very vulnerable. He contracted a virus that sent him to the ER, and he had nobody there for him. He didn't have me for the first time. It was very difficult for both of us. ***I almost had a mental breakdown – all the worry and helplessness – the mental and physical are so connected.*** *The mental breakdown started to make me feel sick myself. I wish there was someone I could go to and say, 'this is my situation, can I please get help?"*

-Yang

Source: Transplant Caregiving: A Call for System Change

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The Support Caregivers Need

Stress & Emotional Support

- 30% need help managing emotional and physical stress

Information & Training on Safety

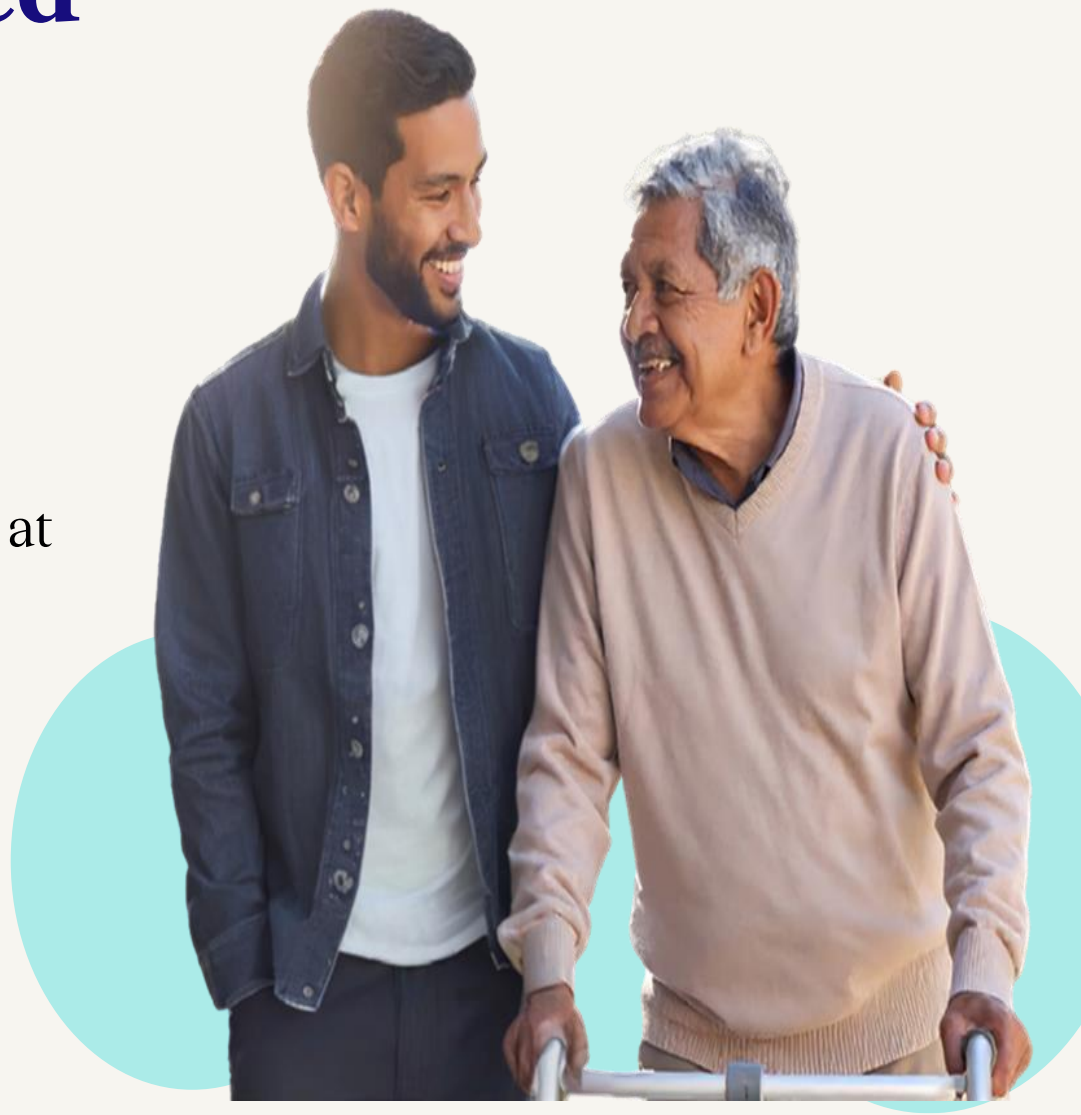
- 27% need guidance to keep their care recipient safe at home

Help Navigating the System

- 26% need assistance managing their recipient's paperwork and eligibility for services

Care Coordination

- 26% report coordinating care is “very” or “somewhat difficult”



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"Nothing fulfills our lives more than caring for our loved ones but for us to sustain that care, to keep them out of the hospital system, we need to sustain ourselves.

- Parvathy

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MAYO CLINIC | Robert D. and Patricia E. Kern Center for the Science of Health Care Delivery

MAYO CLINIC'S CAREGIVER SUPPORT PROGRAM

PRACTICAL METHODS FOR INTEGRATING CAREGIVERS INTO CARE DELIVERY
NATIONAL ALLIANCE FOR CAREGIVING
MAY 27, 2026

Joan Griffin, PhD

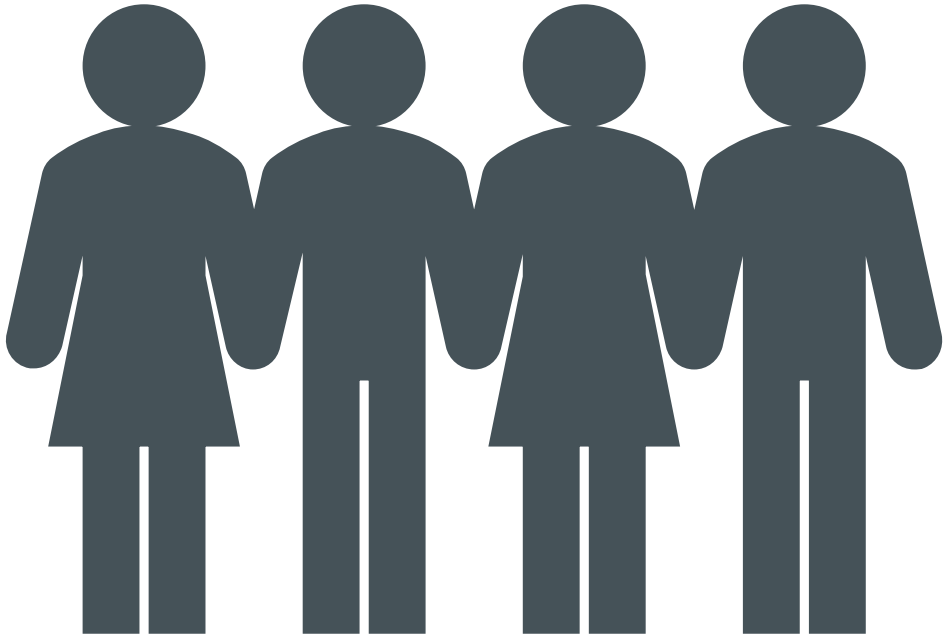
ADDRESSING CAREGIVER SUPPORT IN INPATIENT SETTINGS

- Family caregivers of patients with serious illnesses play a vital role in patient safety and well-being.
- Compared with non-caregivers, caregivers face higher risks for depression, anxiety, and poorer health.
- Health care providers do not feel they have the tools or systems in place to support caregivers while attending to patient care, safety and well-being.
  - Griffin, J.M., Riffin, C., Bangerter, L.R., Schaepe, K. and Havyer, R.D., 2022. Provider perspectives on integrating family caregivers into patient care encounters. *Health Services Research*, *57*(4), pp.892-904.

- *Can we meet caregiver support needs by integrating affordable caregiver support into healthcare systems without interfering with hospital and clinical workflows?*

CAREGIVER SUPPORT PROGRAM

Initiated in 2021 as a pilot program, the Caregiver Support Program (CSP) consists of two social workers and highly trained volunteers who provide **peer support to family caregivers of hospitalized patients.** Peer support includes counseling, assistance with navigating the hospital and complicated healthcare issues, and referrals to community services and agencies.



Modeled after the Ken Hamiliton Center: Ken Hamilton Caregivers Center - Northern Westchester Hospital - Mount Kisco, New York | Northwell Health

WHAT WAS THE METHODOLOGICAL APPROACH?

AIM: Evaluate the feasibility, acceptability and preliminary effectiveness of the CSP

- **Design:** Interrupted time series
  - Data collected pre-launch and 1 year post-launch from staff on three hospital units
  - Data collected pre-launch from caregivers of hospitalized patients on selected floors and consecutively after that from caregivers who interacted with CSP.
- **Sample:** Unit staff and caregivers
- **Setting:** Mayo Clinic-Arizona, three hospital units primarily serving transplant patients.

WHAT WAS THE METHODOLOGICAL APPROACH?

- **Outcomes and Measures:**
  - **Feasibility Measures**
    - Number of FCP contacts and FCPs seen
    - Contact hours and average time spent with FCPs
    - Volunteer attrition rates
  - **Staff Acceptability Measure**
    - Level of engagement
    - Perceived value to patients and FCPs
    - Interruptions to clinical workflow
    - Changes in workflow
  - **FCP Acceptability Measure**
    - Helpfulness of CSP
  - **Care Quality**
    - Staff burnout/depersonalization
    - Staff's compassionate care
    - FCP Communication quality with staff
    - FCP preparedness for caregiving
- **Analyses:**
  - Simple descriptive comparisons

*FCP-Family care partner; CSP=Caregiver Support Program

WHAT DID YOU FIND?

1. Griffin JM, Vitagliano LM, Wold AK, Yee C, Van Der Walt C, Whiteside K, Hansen BB, Chesak S, Strader KD, Meltzer EC, Drake A. Developing and Evaluating an Inpatient Caregiver Support Program: Feasibility, Acceptability, and Perceived Impact. *Mayo Clinic Proceedings: Innovations, Quality & Outcomes.* 2026 Apr 1;10(2):100704.
2. Smiley, A., Griffin, J.M., Vitagliano, L.M., Wold, A.K., Mailloux, T., Hansen, B.B., Strader, K.D., Chesak, S., Khera, N. and Burns, M.R., 2025. Peer Support for Caregivers: An Acute Care Quality Improvement Initiative. American Journal of Medical Quality, 40(4), pp.208-209.

- **Feasibility Measures**
  - Number of FCP contacts and FCPs seen: *487 visits with 253 care partners*
  - Contact hours and average time spent with FCPs: *282 hours of support; visits averaged 20 minutes, but ranged from 2 to 150 minutes*
  - Volunteer attrition rates: *0%*
- **Staff Acceptability Measure**
  - **Level of engagement:** ***50% engaged with CSP; significant increase (26%) in knowledge about CSP***
  - Perceived value to patients and FCPs: *No significant change*
  - Interruptions to clinical workflow: *No significant change*
  - **Confidence in meeting FCP needs:** ***Significant increase (15%) in confidence***
- **FCP Acceptability Measure**
  - **Helpfulness of CSP:** ***90% reported CSP to be very to extremely helpful***
- **Care Quality**
  - **Staff burnout/depersonalization: S*ignificant decrease in burnout/callousness***
  - Staff's compassionate care: *No significant change*
  - FCP communication quality with staff: *No significant change*
  - FCP preparedness for caregiving: *No significant change*

*FCP-Family care partner; CSP=Caregiver Support Program

WHAT IS THE STATUS OF THE PROJECT NOW?

- Hospital-wide implementation at Mayo Clinic Arizona
- Ongoing support from benefactors
- Planning for a comprehensive caregiver support program that would include expansion of the CSP to other sites and coordination with complementary services (e.g., Mayo Clinic Connect, Palliative Care support services, Cancer Education)

HOW DID YOU DEVELOP THE CSP?

STEERING COMMITTEE

Research	Care Management
Office of Patient Experience	Nursing Leadership
Physician Champion	Volunteer Services
Social work	Chaplaincy

STAKEHOLDER ENGAGEMENT – TWO TARGET UNITS

Program introduced to Practice Committees and Departments
Email sent to Physicians and unit staff
Frequently asked questions
Lunch and Question session for staff on launch date

VOLUNTEER TRAINING CURRICULUM

Classroom training (8 hours)	On the floor training (3-4 months)
Role/scope, HIPPA/confidentiality, safety	Debriefing following independent meetings with caregivers
Basic communication (active listening, empathetic responding, non-verbal communication, encouraging self-care)	Debriefing following independent meetings with caregivers
Advanced communication (de-escalating emotion, service recovery, safety concerns)	Ongoing training re: their scope and how and when to hand off to staff
Resources for caregiver and self	Monthly team meetings

PHASED IMPROVEMENTS

	Phase 1				Phase 2		
Data source	Unit	T0	T1	Intervention modifications made; CSP services continue	Unit	T0	T1
Staff survey	1	Pre-launch	1 yr post-launch		3	Pre-launch	7 month post-launch
	2	Pre-launch	1 yr post-launch				
Caregiver survey	1	Pre-launch	Throughout yr 1 post-launch		3	Pre-launch	Throughout 7 months post-launch
	2	Pre-launch	Throughout yr 1 post-launch				

CHALLENGES TO IMPLEMENTATION

Identification challenges and processes
Assessment and hand-offs
Volunteer retention
Challenges with referrals
Buy-in from hospital unit staff
Boundary Setting—Scope of Practice
Financial support for managers
Space
Scaling up to additional resources

CAREGIVER SUPPORT PROGRAM TEAM

- Lynne Vitagliano, MSW, LCSW
- Angie Wold, MSW, LCSW
- Beverly Hansen, MSW
- Kelli Strader
- Ellen Meltzer, MD
- Tish Mailloux, CAVS
- Kairin Whiteside, CAVS
- Jackie Barr, CAVS
- Cathy Zehring. RN, ACM, MM, BSN
- Michelle Burns, MSW
- Amber Drake, MSN, MBA
- Nandita Khera, MD
- Sherry Chesak, PhD
- Eric Cruz
- Yahaira Perez Gonzalez
- Claire Yee, PhD
- Charles Van Der Walt, BS

CONTACT INFORMATION

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MICHIGAN CAREGIVER NAVIGATION PILOT

May 27th, 2026

Joshua Suire, MHA, BSN, RN
Director, Safety & Quality

MHA Keystone Center
A Certified Patient Safety Organization

WELCOME AND OBJECTIVES

- Perform an overview into the MHA Keystone Center Michigan Caregiver Navigation Toolkit.
- Review the gap analysis tool that drives programming.
- Evaluate outcomes from a large academic medical center in southeast Michigan who piloted the toolkit over a two-year implementation period.
- Discuss next steps and hopes for expansion across Michigan.

MHA CAREGIVER NAVIGATION TOOLKIT HISTORY

MICHIGAN

CAREGIVER NAVIGATION TOOLKIT

MHA Keystone Center
A Certified Patient Safety Organization

DEFINING A CAREGIVER

For the purposes of this toolkit, a caregiver is defined as:
any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition.

These individuals may be:

- Primary or secondary caregivers

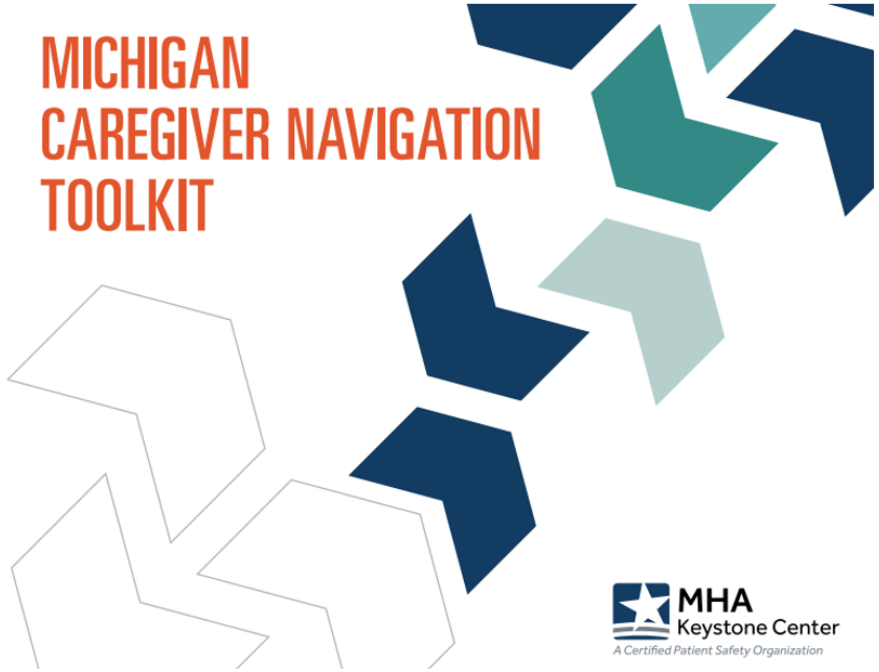
Typically, this is an unpaid role

- Live with or separately from, the person receiving care.

- May care for their care recipient with function (e.g., activities of daily living) or health needs (e.g., chronic or acute illness such as cancer or dementia).[2]

DEFINING THE 7 DOMAINS OF PROGRAMMING

7 Domains of Caregiving



- Healthcare staff
- Assessments
- Community partnerships
- Education
- Integration into systems
- Marketing & referrals
- Monitoring, evaluation & sustainability

CAREGIVER PROGRAMING GAP ANALYSIS

DOMAIN	FUNDAMENTAL	ADVANCED
Healthcare Staff	• Name an executive sponsor (C-suite support). • Identify frontline champions. • Assign a project manager to oversee program development. • Identify primary pilot group members (employee track versus patient/caregiver track).	• Budget dedicated healthcare staff time. • Train dedicated healthcare staff. • Consider: Caregiver Patient Navigators, C.A.R.E. Program Specialist (or other title(s)). • Foster dedicated ancillary support (volunteers, IT, administrative).
Assessments	• Ensure compliance with The Michigan Caregiver Designation Act (inpatient only). • Build Electronic Health Record (EHR) questions and clinical workflows. • Choose standardized assessments to identify caregivers (e.g., patient as a caregiver, caregiver burden/coping).	• Implement standardized caregiver assessments (e.g., Zarit). OR • Conduct individualized conversations with trained staff (health coaching).
Community Partnerships	• Perform an environmental scan of the community. • Network and align common goals. • Develop organizational Person and Family Advisory Council (PFAC).	• Create formal partnerships with key community organizations (e.g., Program of All-Inclusive Care for the Elderly). • Initiate involvement in community collaboratives.
Education	• Educate staff on The Michigan Caregiver Designation Act. • Identify caregiver educational materials and develop a catalog of ongoing and past events. • Work with community partners to provide resources and facilitate education.	• Support ongoing staff and provider education and awareness on programming (consider continuing education credit). • Implement advance care planning (e.g., advanced directives). • Provide a dedicated person for support groups and 1:1 concierge service offerings. • Develop consistent educational sessions for caregivers and the community. • Conduct specialized programs based on feedback and needs.
Integration into Health Systems	• Revise patient visitor policies to include public health emergencies. • Identify current resources and capacity. • Identify piloted service line to deploy programming. • Perform gap analysis and develop action plans for desired state (using SMART Goals).	• Once desired state is achieved, spread programming throughout other service lines. • Develop a caregiver employee resource group. • Include programming in new hire orientation. • Convene an internal governing body (e.g., PFAC, quality department, performance excellence, population health) to have the program report to. • Include caregiver program information on all discharge documents.
Marketing and Referrals	• Create website with referral link. • Develop dedicated marketing materials. • Initiate a communications plan (e.g., newsletters).	• Create EHR integration opportunities (e.g., referral orders). • Perform employee needs assessment (for employee track). • Set-up a dedicated phone number that is monitored.
Program Monitoring, Evaluation & Sustainability	• Identify priority process and outcome metrics. • Measure impact by embedding outcomes/impact into new or existing quality metrics.	• Develop internal dashboard around chosen metrics. • Share learnings with other Michigan hospitals.

YEAR 1

Program Launch

- Select caregiver navigation program track and piloted service line.
- Identify a clear current state and desired state.
- Complete gap analysis at the beginning of the first year.
- Identify process, outcome and self-reported metrics.
  - See examples in Section 7.
- Form program team and develop a fundamental action plan addressing the seven domains using SMART Goals.
- Implement the fundamental action plan.

YEAR 2

Full Implementation

- Evaluate previous year's fundamental action plan using Plan, Do, Study, Act (PDSA) methodology. Complete a gap analysis at the beginning of the second year.
- Track process, outcome and self-reported metrics consistently.
  - See examples in Section 7.
- Form an advanced action plan addressing the seven domains using SMART goals.
- Implement advanced action plan.

YEAR 3

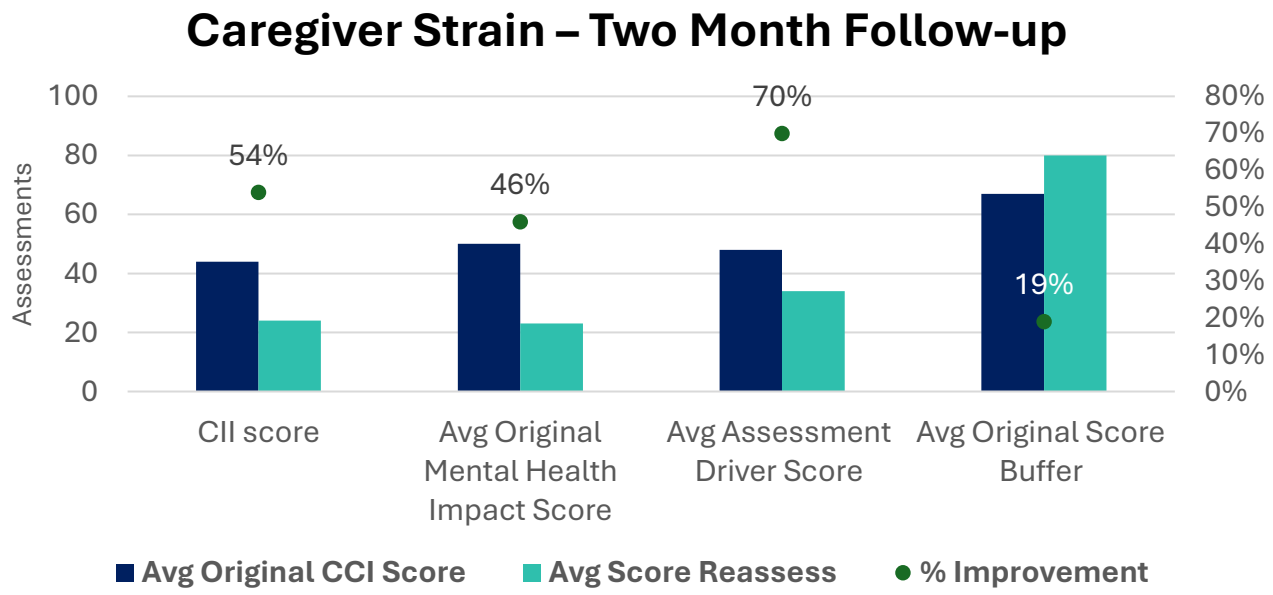
Maturation and Sustainability

- Evaluate previous year's advanced action plan using PDSA methodology.
- Complete a gap analysis at the beginning of the third year.
- Create evaluation and sustainability plan with tracked metrics.
- Form an action plan focusing on any unaddressed advanced interventions as well as plans for widespread adoption outside of chosen piloted service line.

PILOT DATA FOR CAREGIVER STRAIN PROGRAM
TWO MONTH FOLLOW-UP

Indicator	Avg Original CCI Score	Avg Score Reassess	% Improvement
CII score	44	24	54%
Avg Original Mental Health Impact Score	50	23	46%
Avg Assessment Driver Score (driver of strain)	48	34	70%
Avg Original Score Buffer (buffers to stress)	67	80	19%

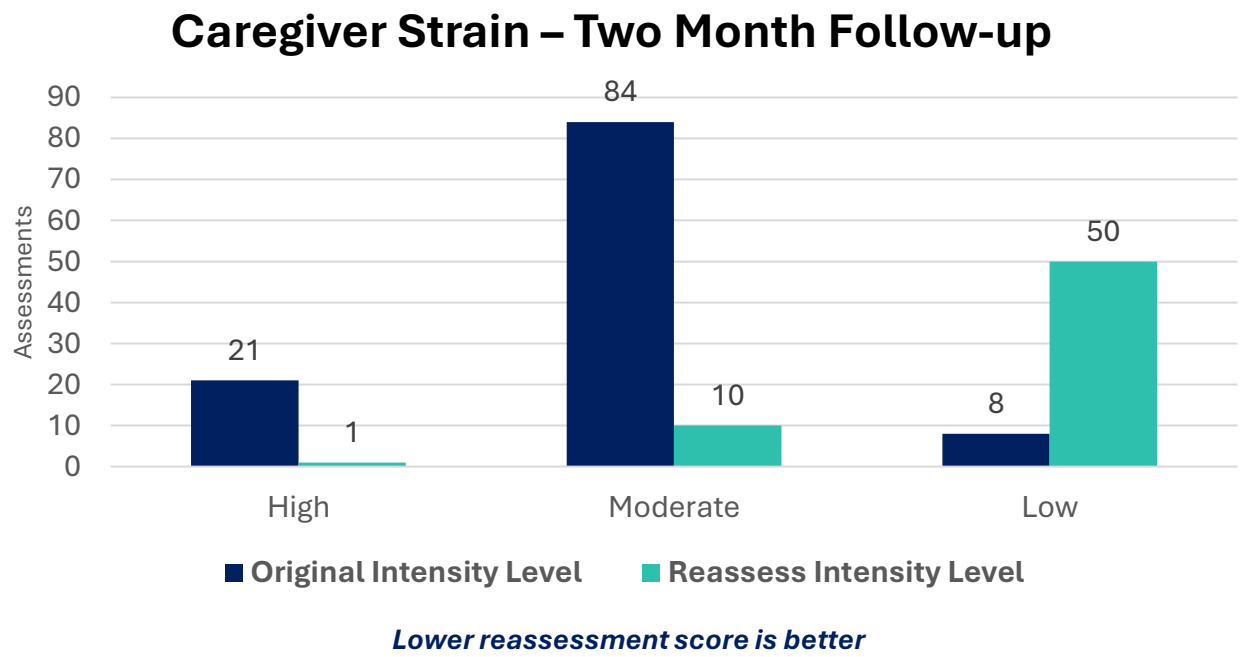
Patient denominator = 113
113 cases reassessed
Data through 9/21/2025



PILOT DATA FOR CAREGIVER STRAIN PROGRAM
TWO MONTH FOLLOW-UP

Intensity	Original Intensity Level	Reassess Intensity Level
High	21	1
Moderate	84	10
Low	8	50

Patient denominator = 113
61 cases reassessed
Data through 9/21/2025



Interpretation

Caregiver-Centered Interventions

Interventions focused on caregivers reduce repeat emergency department visits by increasing confidence and preparedness.

Operational Benefits

Reduced ED visits decrease congestion, lower costs, and free clinical capacity for higher-acuity patients.

Strategic Leadership Actions

Leaders should expand caregiver support and integrate assessments to improve system efficiency and patient experience.

Recommendations

Expand Caregiver Assessment

Widening caregiver assessments can reduce repeat emergency visits, especially for high-risk populations.

Monitor ED Visit Frequency

Tracking total emergency department visits is more effective than simple yes/no metrics for intervention evaluation.

Address Caregiver Stressors

Tailored interventions should target financial strain, preparedness, and emotional burden among caregivers.

Invest in Predictive Analytics

Using analytics to identify at-risk patients can improve resource allocation and care continuity.

Reduced Emergency Department Visits

The intervention led to 11 fewer ED visits per 100 patients within 30 days, showing strong clinical value.

Extended Positive Outcomes

Favorable trends in ED, Observation, and Inpatient utilization were observed over 60 and 90 days post-discharge.

Operational and Cost Benefits

Reducing ED visits decreases strain on resources and enhances patient experiences, suggesting cost-saving potential.

CLOSING & NEXT STEPS

National Caregiver Support Collaborative
Building our capacity to support family, kinship, and tribal caregivers

Caregivers As Partners in Care Teams

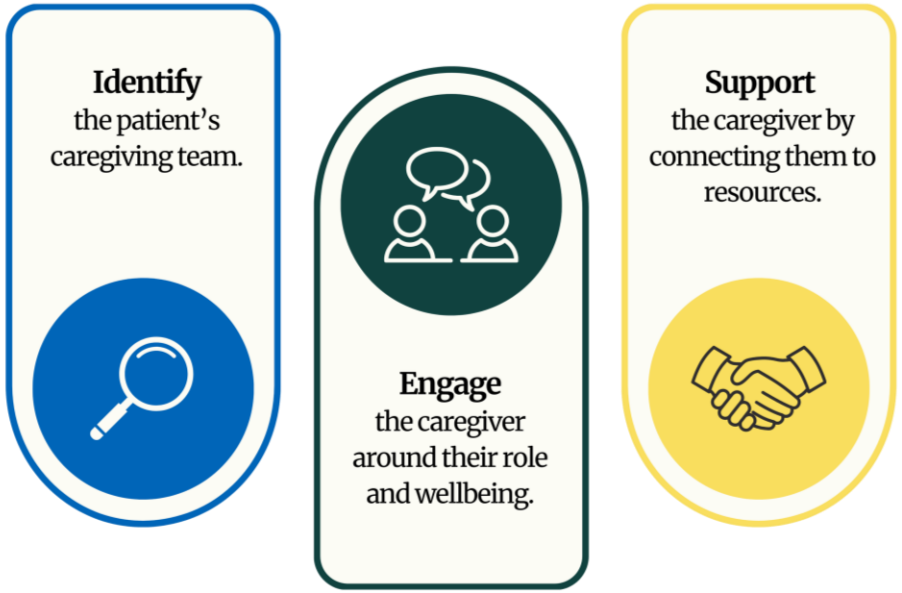
Recognizing Caregivers as Care Team Members: Using New Medicare Fee-For-Service Billing Codes in Practice

Josette Rivera, MD
University of California, San Francisco (UCSF)
May 27, 2026

National Caregiver Support Collaborative

Caregivers As Partners in Care Teams

Caregivers As Partners in Care Teams (CAP-CT)



- Educates health care professionals to include family caregivers in a patient's care journey
- Provides free training and resources for healthcare teams and the Aging Network
- Advances the Administration for Community Living (ACL)'s National Strategy to Support Family Caregivers, Goal 2

Agenda

1. Welcome
2. CTS and CHRA Codes
3. HRSN Codes
4. Billing Guide Resources Overview
5. Closing

Note: CTS = Caregiver Training Services; CHRA = Caregiver Health Risk Assessment; HRSN = Health-Related Social Needs

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Caregivers As Partners in Care Teams

Why CTS, CHRA, and HRSN Codes Matter

- These codes make services care team members provide to support caregivers *billable* and *reimbursable*
- Before these codes existed, even when providers were doing this work, there was no mechanism to capture it in the billing record or receive reimbursement for it, which made it economically unsustainable for many practices
- CTS and CHRA codes:
  - Are used for training and assessing caregivers directly
- HRSN codes:
  - Address upstream social and economic drivers of health, which caregivers often manage on a patient's behalf
  - Address the broader social context caregivers navigate in supporting patients

Note: CTS = Caregiver Training Services; CHRA = Caregiver Health Risk Assessment; HRSN = Health-Related Social Needs

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Caregivers As Partners in Care Teams

CTS and CHRA Codes: *What They Do*

- **What are CTS and CHRA codes?**
  - These codes allow healthcare professionals to directly train and educate caregivers and to assess their well-being
  - The caregiver is the recipient of the service, which is furnished to help them carry out the patient's treatment plan
- **Consider these two questions as you get started:**
  - Does the caregiver need support to carry out the patient's treatment plan?
  - Is the service being provided by provider a physician, NPP, or authorized auxiliary personnel?

Note: Non-physician practitioners (NPPs) include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), physician assistants (PAs), and clinical psychologists (CPs)

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CTS and CHRA Codes: *What They Cover*

The codes cover three categories of caregiver training and a caregiver assessment:

Behavior Management

Training on patient behavior and environment management

Functional Performance

Training to facilitate caregivers' support of patients' activities of daily living (ADLs) and mobility

Direct Care Strategies and Techniques

Training for chronic care, wound care, and infection control

Caregiver Health Risk Assessment

Standardized assessment of caregiver stress and well-being

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CTS and CHRA Codes: *Billing and Documentation Essentials*

- **Who can bill?** Physicians, non-physician practitioners, and authorized auxiliary personnel under supervision
  - Physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs) can bill Functional Performance and Direct Care codes if they are furnished as part of a patient's therapy plan of care
  - Clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) can bill directly for CTS related to mental illness diagnosis or treatment
- **Documentation essentials:**
  - Patient consent must be documented in the medical record (no signed form required)
  - The patient cannot be present during training
  - There is no limit on how many times codes can be billed
  - All codes are eligible for telehealth

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HRSN Codes: *What They Do*

- **What are HRSN codes?**
  - They allow healthcare professionals to bill for addressing the upstream drivers of a patient's health, factors that caregivers may already be responsible for managing on a patient's behalf
- **Consider these two questions as you get started:**
  - Could the patient have upstream drivers limiting their ability to be diagnosed or treated?
  - Is the service being provided by a physician, NPP, or authorized auxiliary personnel?

Note: Non-physician practitioners (NPPs) include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), physician assistants (PAs), and clinical psychologists (CPs)

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Caregivers As Partners in Care Teams

HRSN Codes: *What They Cover*

The codes cover four categories of service addressing upstream drivers of health:

Community Health Integration (CHI)

Addresses non-medical factors limiting care through coordination, education, and navigation

Principal Illness Navigation (PIN)

Helps patients understand their condition and navigate treatment

PIN Peer-Support (PIN-PS)

PIN services provided from someone with lived experience

Physical Activity and Nutrition Assessment

A standardized assessment of physical activity and nutrition risk

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Caregivers As Partners in Care Teams

HRSN Codes:
Billing and Documentation Essentials

- **Who can bill?**
  - Physicians, NPPs, and authorized auxiliary personnel (including CNSs)
  - CSWs, MFTs, and MHCs can bill CHI, PIN, and PIN-PS directly when services relate to mental illness and substance use disorders
- **Documentation essentials:**
  - There must be an initiating visit (e.g., evaluation and management visit, annual wellness visit) before HRSN services can be billed
  - Patient consent must be documented in the medical record
  - CHI, PIN, and PIN-PS are not telehealth-eligible, but services can be delivered via phone or secure messaging; Physical Activity and Nutrition Assessments are telehealth-eligible

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Caregivers As Partners in Care Teams

Overview of Billing Guides

- CAP-CT, National Caregiver Support Collaborative, and ATI Advisory, with support from the Administration for Community Living and the Department of Health and Human Services, created two quick-reference guides to facilitate billing of these codes
- Each guide is structured as a flow chart to help providers quickly identify the right billing code based on their specific clinical situation
- Both guides were recently updated to reflect the Calendar Year 2026 Physician Fee Schedule

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Caregivers As Partners in Care Teams

CTS/CHRA Billing Guide

Billing Guide for Medicare Fee-for-Service Caregiver Training Services (CTS) and Caregiver Health Risk Assessment (CHRA) Codes[1]

CTS and CHRA codes allow health care professionals to bill for providing training to and assessments of caregivers.

This guide reflects the latest as of the CY 2026 CMS Physician Fee Schedule (PFS) Final Rule; the PFS is updated annually.

If the answers to these two questions are "yes," you can bill these codes:

A. Does the caregiver need support to aid in carrying out the patient's treatment plan?[2]

B. Is the provider a physician, non-physician practitioner (NPP), or auxiliary personnel billing under the direction of a physician or NPP?

What kind of training/assessment will be provided?

Behavior Management[3]		Functional Performance[3,4]		Direct Care Strategies and Techniques[3,4]		Caregiver Health Risk Assessment
How to structure the patient's environment to support and reinforce desired patient behaviors and reduce the negative impacts of the patient's diagnosis on the patient's daily life; how to develop technical skills to manage the patient's behavior.		How to facilitate the patient's activities of daily living (ADLs), transfers, mobility, communication, and problem-solving to reduce the negative impacts of the patient's diagnosis on the patient's daily life and assist the patient in carrying out a treatment plan.		How to support care for patients with an ongoing condition or illness and reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control).		Administration of a standardized health risk assessment (HRA) tool to assess a caregiver's stress, well-being, or other issues that could impact the patient's care.[5]
Who will be trained?		**Who will be trained?**		**Who will be trained?**		**Who will be assessed?**
Caregiver(s) of one patient	Caregiver(s) of multiple patients	Caregiver(s) of one patient	Caregiver(s) of multiple patients	Caregiver(s) of one patient	Caregiver(s) of multiple patients	Individual caregiver
Consider billing this code![6]	**Consider billing this code![6]**	**Consider billing this code![6]**	**Consider billing this code![6]**	**Consider billing this code![6]**	**Consider billing this code![6]**	**Consider billing this code![6]**
G0539: First 30 minutes[7,8] **G0540:** Each additional 15 minutes[7,8]	**96202:** First 60 minutes[7,8,9] **96203:** Each additional 15 minutes[7,8,9]	**97550:** First 30 minutes[7,8] **97551:** Each additional 15 minutes[7,8]	**97552:** Bill per session[7,8,9]	**G0541:** First 30 minutes[7,8] **G0542:** Each additional 15 minutes[7,8]	**G0543:** Group training with multiple sets of caregivers[7,8,9]	**96161:** Duration of encounter not specified (billed per standardized assessment); assessment administered to caregiver of an individual beneficiary

Important: *For Behavior Management, Functional Performance, and Direct Care Strategies and Techniques codes, the patient cannot be present but must provide consent. Patient consent must be documented in their medical record, but a signed form is not required. The CHRA may be furnished without the patient present, but the treating practitioner must receive the patient's consent for the caregiver to receive the assessment.*

HRSN Billing Guide

Billing Guide for Medicare Fee-for-Service Health-Related Social Needs (HRSN)[1]

HRSN codes allow health care professionals to bill for addressing upstream drivers (social and economic factors) that affect the patient's health, which caregivers are often responsible for managing.

This guide reflects the latest as of the CY 2026 CMS Physician Fee Schedule (PFS) Final Rule; the PFS is updated annually.

If the answers to these two questions are "yes," you can bill these codes:

A. Could the patient have upstream drivers that need identification or that might be limiting the ability to diagnose or treat the patient?

B. Is the provider a physician, non-physician practitioner (NPP), or auxiliary personnel billing under the direction of a physician or NPP?

Important: *Before receiving the following services, patients must have an initiating visit, which is separately billable and reimbursable, where the billing practitioner identifies unmet HRSN. The initiating visit includes evaluation and management (E/M); transitional care management; annual wellness visits (AWV); psychiatric diagnostic evaluation; or Health Behavior Assessment and Intervention (HBAI) services. The initiating visit must be performed by the same billing provider who will bill for subsequent services or by certified or trained auxiliary personnel under the direction of the billing provider.*

What is the service aiming to address?

Community Health Integration (CHI)[2]	Principal Illness Navigation (PIN)[2]	Principal Illness Navigation – Peer Support (PIN-PS)[2,3]	Physical Activity & Nutrition Assessment[4,5,6]
CHI services help address non-medical factors that may be limiting the ability to diagnose or treat problem(s) addressed in the patient's initiating visit.	PIN services help patients understand their condition or diagnosis and navigate treatment.	PIN peer-support services help patients understand their condition or diagnosis and navigate treatment.	Administration of a standardized, evidence-based assessment of physical activity and nutrition.
Services Provided	**Services Provided**	**Services Provided**	**Services Provided**
• Care coordination • Health education • Health system navigation • Patient self-advocacy training • Social and emotional support	• Care coordination • Facilitating behavior change • Health education • Identification or referral to appropriate services • Patient-centered assessment • Referral to supportive and community-based services • Self-advocacy skills • Social and emotional support	• Assistance in communicating with healthcare and social care providers • Facilitating behavior change • Health education • Identification or referral to appropriate services • Leveraging lived experiences to provide support • Patient-centered interview • Referral to supportive and community-based services • Self-advocacy skills • Social and emotional support	• Assessing risk related to the root causes of chronic conditions to support disease prevention and improvement of chronic disease management
Consider billing this code![6]	**Consider billing this code![6]**	**Consider billing this code![6]**	**Consider billing this code![6]**
G0019: 60 minutes per calendar month **G0022:** Each additional 30 minutes per calendar month	**G0023:** 60 minutes per calendar month **G0024:** Each additional 30 minutes per calendar month	**G0140:** 60 minutes per calendar month **G0146:** Each additional 30 minutes per calendar month	**G0136:** 5 to 15 minutes, not more often than every 6 months

National Caregiver Support Collaborative

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Thank you

Questions?

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Frequently Used Terminology

- **Auxiliary personnel:** Any individual acting under the supervision of a physician or other practitioner, regardless of whether they are an employee, leased employee, or independent contractor
- **Non-physician practitioners (NPPs):** Include nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), physician assistants (PAs), and clinical psychologists (CPs)
- **Reasonable and necessary:** Services integral to a patient's overall treatment, furnished after the treatment plan is established, where caregiver involvement is needed to ensure a successful treatment outcome
- **Therapy plan of care:** A plan that enables billing for Functional Performance and Direct Care codes when services are furnished under the direction of a physical therapist (PT), occupational therapist (OT), or speech-language pathologist (SLP)
- **Treatment plan:** A patient-centered plan of care that appropriately accounts for clinical circumstances

Discussion & Questions

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