NACDD CHRONIC DISEASE CONNECT WEBINAR – JULY 9, 2026

Sustaining Diabetes Prevention and Management through Leveraging Community Health Integration (CHI) and Principal Illness Navigation (PIN) Implementation Codes

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS

Promoting Health. Preventing Disease.

Webinar Presenter & Moderator

Susan Buell

Public Health Consultant,
Diabetes Team
NACDD

Learning Objectives

By the end of this webinar, participants will be able to:

1. Describe key findings from Years 1 and 2 of the PHIC Community Care Hub project related to enrollment, retention, and health outcomes in the National DPP Lifestyle Change Program and DSMES services.
2. Explain how Community Care Hubs can support coordination of health-related social needs and strengthen pathways for reimbursement of community-based services.
3. Identify partnership and sustainability strategies that state health departments and their partners can use to expand access to National DPP LCP and DSMES services.
4. Apply lessons learned from the demonstration project to improve referral systems and collaboration among public health, Medicaid, healthcare, and community-based organizations.

Strengthening Public Health Systems and Services Through National Partnerships to Improve and Protect the Nation's Health is supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, CDC/HHS, or the U.S. Government.

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Today's Panelists

			
Devin Worster, MD, MPH **Assistant Professor of Medicine, Weill Cornell Medicine; Affiliate Faculty, Cornell Health Policy Center**	Sherri Ohly, BSW **SME CHI/PIN Codes**	Lisa Coombs-Gerou, Ed.D candidate, ED.S, MPA, **SME Community Health Strategy and Implementation**	Nikki Kmicinski, MS, RD, CDN **CEO, Western NY Integrated Care Collaborative**

Project Team

- Today's Project Team includes:
  - Centers for Disease Control and Prevention, Division of Diabetes Translation (DDT)
  - Administration for Community Living (ACL)
  - National Association of Chronic Disease Directors (NACDD)
  - Leavitt Partners (Health Management Associates)
  - The Kem C. Gardner Policy Institute, University of Utah
  - Third Horizon

Today's Agenda

1. Welcome and Topic Introduction
2. Community Care Hubs: Expanding Hub Models to Advance Community-Based Health Care
3. Overview of CHI and PIN Codes
4. Panel Discussion: Sustainability Strategies for Hubs Through CHI and PIN Codes
5. Participant Q&A
6. Wrap Up and Next Steps

Setting the Stage:

Sustainable Community-Based Care Infrastructure

Susan Buell, NACDD Diabetes Team SME

Why Community Care Hubs Matter

The Challenge:

Healthcare alone accounts for only a portion of health outcomes.

Communities face:

- Rising chronic disease rates
- Health-related social needs
- Fragmented referral systems
- Limited coordination between healthcare and community organizations
- Unsustainable funding for community-based services

The Opportunity:

CCHs create the infrastructure needed to connect healthcare, public health, social care, and community organizations at scale.

Community Care Hubs (CCHs): Expanding Hub Models to Advance Community-Based Health Care

Community Care Hubs	Umbrella Hub Arrangements	Partner Networks
• Consists of lead organization, community-based organizations (CBOs), health care organizations, and social service providers • Includes **multiple** evidence-based programs • Centralizes administrative and operational functions, including payer contracting and billing • Receives funding through multiple blended and braided funding streams, including payer reimbursement • Advances access to social services to resolve health-related needs	• Consists of lead organization (umbrella hub organization (UHO)) and subsidiary partners, including CBOs • Focuses on the National Diabetes Prevention Program (National DPP) lifestyle change program • Allows the umbrella hub arrangement (UHA) to operate as a single Medicare Diabetes Prevention Program (MDPP) supplier and share CDC-recognition status with subsidiaries • Centralizes administrative and operational functions, including payer contracting and billing • Pursues sustainability through payer reimbursement for subsidiary organizations, including CBOs	• Consists of multi-sectoral partners (CBOs, health care organizations, institutions, employers, payers, and community representatives) • Focuses on organizations working together to achieve a common goal for population or systems level change • Coordinated by a backbone organization • Aims to promote health for all and serve populations at greatest risk for diabetes and its complications

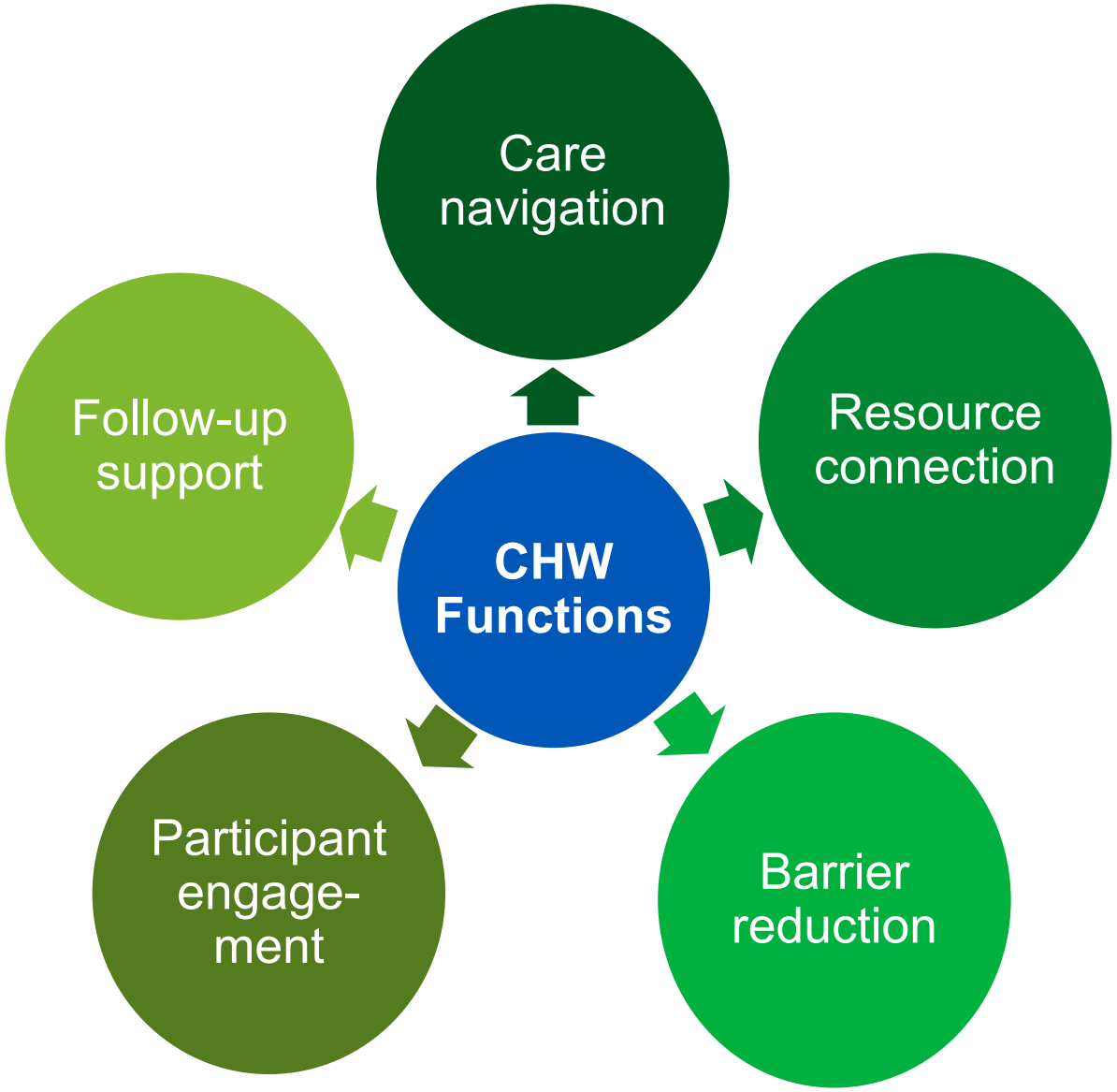
What is a Community Care Hub?

A CCH is Infrastructure, NOT a Program

A CCH doesn't replace community organizations—it enables them to operate as part of an integrated healthcare ecosystem.

CCHs help healthcare organizations achieve outcomes they cannot achieve alone.

Community Health Workers Make Community-Clinical Integration Successful



Community Health Workers Strengthen Integration

Within CCHs, CHWs help to bridge healthcare and community services.

Exploring the Codes:

Community Health Integration (CHI) and Principal Illness Navigation Codes (PIN)

Devin Worster, MD, MPH
Assistant Professor of Medicine, Weill Cornell Medicine; Affiliate Faculty, Cornell Health Policy Center

CHI & PIN: New Payment Pathways

In 2024, Medicare introduced Community Health Integration (CHI) and Principal Illness Navigation (PIN) service codes for reimbursement

→ **CHI:** Addresses health-related social needs (assessment, care planning, education)

→ **PIN:** Supports patients with high-risk conditions through navigation and coordination

CHI and PIN codes **create new reimbursement pathways**, enabling community-based organizations and CCHs to **diversify funding** and **develop sustainable revenue streams**.

Who Is Eligible for CHI and PIN Services?

All:

- Medicare Part B Beneficiaries
- Have given consent for services
- Have had an initiating visit prior to services start

CHI:

- Have needs related to unmet upstream drivers of health (e.g., food, housing, transportation, or utility insecurity)
- Have had an initiating visit prior to CHI service start

PIN:

- Have one or more high-risk conditions expected to last more than three months (e.g. diabetes, hypertension, heart failure, cancer, HIV)

PIN-PS: Peer Support

- Have one or more high-risk behavioral health condition (severe mental illness, substance use disorder (SUD), lasting 3+ months

Who Delivers CHI and PIN Services?

All/CHI (Community Health Integration)

- Authorized billing providers: Physicians, Nurse Practitioners, Physician Assistants, Certified Nurse Midwives
- Auxiliary personnel (under general supervision): Community Health Workers, Social Workers, Nurses
- Service delivery may be in-house or through contracted community-based organizations

PIN:

- Behavioral health practitioners
- Auxiliary personnel (under general supervision): Community Health Workers, Social Workers, Nurses

PIN-PS (Peer Support)

- Auxiliary personnel: Peer support specialists (with lived experience of mental health or SUD)

CHI and PIN Codes:

Application in Diabetes Prevention and Management

Sherri Ohly, BSW
SME, CHI and PIN Codes

CHI Services

CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, Home and Community Based Services (HCBS) Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, Skilled Nursing Facilities (SNFs)
Coordination of car transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavior change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	

PIN Services

List of PIN Services		
Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.	Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.	Health Education
Practitioner, Home, and Community-Based Care Coordination	Coordination of care transitions	Facilitating access to social services
Building patient self-advocacy skills	Health care access/system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.	

CHI codes	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services (CHI) SDOH 60 min	$80.56	$49.60
G0022	Community Health Integration Services (CHI); add ea. 30 min	$50.26	$34.62
G0511 (FQHCs/RHCs)	Each eligible CHI service	$71.70 (Flat Fee)	

PIN codes	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN Service, 60 minutes per month	$80.56	$49.60
G0024	PIN Service, add ea. 30 min	$50.26	$34.62

PIN-Peer Support codes	Descriptor	Non-Facility Rate	Facility Rate
G0140	PIN-Peer Support, 60 minute	$80.56	$49.60
G0146	PIN-PS, Peer Support, add ea. 30 min	$50.26	$34.62

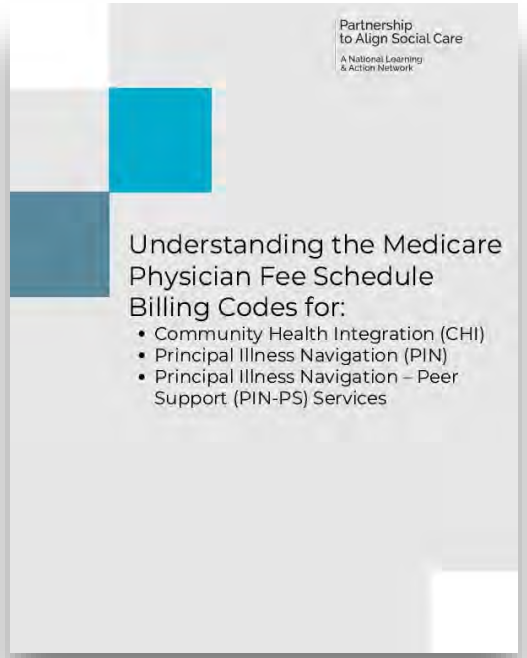
* Rates listed are the National Rate, effective March 9, 2024. As of September, 2025 FQHCs have a separate billing pathway

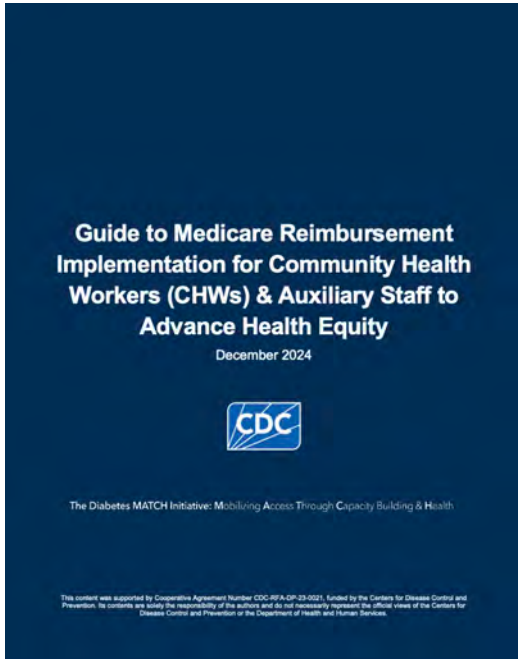
A Few Key Requirements

- A billing provider must initiate and supervise the services
- CHWs must work under general supervision of the provider and follow documentation rules
- CHW supportive supervision is provided by the CHW Supervisor
- Reimbursement is timed-based billing
- Time spent on behalf of the patient is billable time
- CCHs can play a key role in negotiating agreements with providers and supporting documentation requirements

Key Implementation Resources

Key Implementation Resources





CHI and PIN Codes:

Case Example

Lisa Coombs-Gerou, Ed.D(c), ED.S, MPA,
SME Community Health Strategy and Implementation

Example of CHI Code Use in Diabetes Prevention

Case example of addressing prediabetes using CHI codes:

- An individual is screened and identified as living with food insecurity by healthcare team
- Through a conversation with their Case Manager (who could be a CHW and/or a dual-trained CHW/Lifestyle Coach), they share they have a qualifying A1C for the National DPP lifestyle change program
- Case manager/CHW makes connection for food supports and enrolls individual in the National DPP lifestyle change program to receive nutrition education and physical activity support
- CHW tracks their time delivering community health integration services and invoices CHI code billing through partnership agreement(s)

Panel Discussion:

Sustainability Strategies for Hubs Through CHI and PIN Codes

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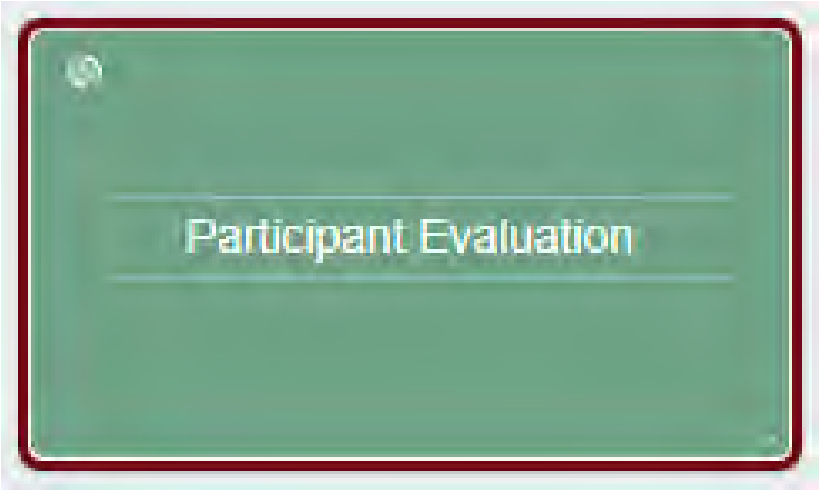
Participant Q&A

Wrap Up and Next Steps

- Slides and summary
- Resources (PDF in Zoom Resources tab)
- Evaluation (at close of webinar)



Resources

- Community Health Integration and Principal Illness Navigation Implementation Guide: https://communityhealthintegration.info/
- NACDD Coverage Toolkit (Hub models): https://coveragetoolkit.org/hub-models/
- What is a Community Care Hub? Center of Excellence: https://coe.aginganddisabilitybusinessinstitute.org/what-is-a-community-care-hub/
- Understanding the Medicare Physician Fee Schedule billing codes for CHI and PIN: https://www.partnership2asc.org/wp-content/uploads/2024/03/FINAL-Understanding-Medicare-PFS-Schedul…
- Community Health Financial Sustainability Toolkit: https://www.envisionchws.org/fst
- Partnership to Align Community Care: https://www.partnership2acc.org