COVID-19 Waiver Allowing HHAs Flexibility for OT to Open Cases – Part 2

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Learning Objectives

1. Describe the components of the comprehensive assessment
2. Identify resources to complete all OASIS items, including Section GG, and the Drug Regimen Review.
3. Distinguish between an occupational therapy evaluation vs. completion of a comprehensive assessment, including purpose, intent, and metrics for assessing function.

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COVID-19 Waivers Impact

- Homebound status/eligibility *for Medicare patients* may be verified over the phone.
- Agency has 30 days from start of care date to complete the comprehensive assessment.
- OT can be the skilled service performing initial assessment visit and/or comprehensive assessment even if OT does not establish eligibility.
- This does not change the fact that OT is not a qualifying service.

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Waiver Clarifications from CMS

- OT may perform the initial and comprehensive assessments when the physician order includes OT and any other skilled service (including SN)
- This flexibility does not extend to PT or SLP when SN is on the order
- It is the SOC (billable) visit when OT is on the order and performs a skill during the assessment

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Start of Care for Home Health

Initial Assessment Visit

- Verify eligibility for home health
- Admit to home health (consent/patient rights/financial responsibility)
- Assess immediate care and support needs

Visit within 48 hours of referral or on physician-designated date.
Performed by a skilled service.
If a skilled service is provided by a discipline on the initial referral (orders), this becomes the official start of care.

Comprehensive Assessment

- OASIS Items
- Drug Regimen Review
- Agency-specific content
- Discipline specific content/evaluation

Must complete within 5 calendar days of SOC
Performed by a skilled service.
May or may not be performed by the same person who conducted the initial assessment visit.

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Comprehensive Assessment 42 CFR §484.55 (c)

(c) Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:

(1)The patient's current health, psychosocial, functional, and cognitive status;

(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;

(3) The patient's continuing need for home care;

(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;

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Comprehensive Assessment 42 CFR §484.55 (c)

(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

(6) The patient's primary caregiver(s), if any, and other available supports, including their:

(i) Willingness and ability to provide care, and

(ii) Availability and schedules;

(7) The patient's representative (if any);

(8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items . . ..

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Comprehensive Assessment

- Understanding the intent and how to organize allows you to:
  - Practice patient-centered rather than data-centered care.
  - Organize your visit/assessment routine so it makes sense to you.
  - Assess and document rather than data screens directing you.
  - Elicit information or performance that is relevant to multiple components of the assessment.
  - Use both interview and direct observation approaches to verify information and ensure accurate understanding of the patient's health, functional status, and circumstances.
  - Work at the top of your license.

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Comprehensive Assessment

- Emphasis is **assessment**.
- What does the agency need to know about this patient and his/her circumstances to:
  - provide appropriate patient-centered care and
  - receive appropriate payment for that care
- Much of the guidance/training focuses on individual data items
- OT can lend accuracy to the Functional Scoring items in the PDGM payment derived from the OASIS, however important to understand the details of data collection

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(M1800)	**Grooming: Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).**
0	Able to groom self unaided, with or without the use of assistive devices or adapted methods.
1	Grooming utensils must be placed within reach before able to complete grooming activities.
2	Someone must assist the patient to groom self.
3	Patient depends entirely upon someone else for grooming needs.

The frequency with which selected activities are performed (such as washing face and hands vs. fingernail care) must be considered in responding. Patients able to do more frequently performed activities (for example, washing hands and face) but unable to do less frequently performed activities (trimming fingernails) should be considered to have more ability in grooming.

OASIS D Guidance Manual, Chapter 3: K1-K2

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(M1820)	Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
0	Able to obtain, put on, and remove clothing and shoes without assistance.
1	Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
2	Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
3	Patient depends entirely upon another person to dress lower body.

The clinician will need to determine which clothes should be considered routine. It will be considered routine because the clothing is what the patient usually wears and will continue to wear, or because the patient is making a change in clothing options to styles that are expected to become the patient's new routine clothing.

If the patient requires standby assistance (a "spotter") to dress ***safely*** or verbal cueing/reminders, enter Response 2.

Regardless if a patient lives alone.

OASIS D Guidance Manual, Chapter 3: K5-K6

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(M1830)	**Bathing**: Current ability to wash entire body safely **Excludes grooming washing face, washing hands, and shampooing).**
0	Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
1	With use of devices, able to bathe in shower or tub independently, including getting in/out of tub/shower.
2	Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas.
3	Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
4	Unable to use shower/tub, but able to bathe self independently with/without use of devices at sink, in chair, or on commode.
5	Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assist or supervision of another person.
6	Unable to participate effectively in bathing and is bathed totally by another person.

Patient's status should not be based on assumption of a patient's ability to perform a task with equipment they do not currently have, preventing assessment.

Medically restricted, or absence of tub/shower, 4, 5, or 6.

OASIS D Guidance Manual, Chapter 3: K7-K8

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(M1840)	**Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
0	Able to get to and from the toilet and transfer independently with or without a device.
1	When reminded, assisted, or supervised by another person, able to get to/from toilet and transfer.
2	Unable to get to and from toilet but is able to use a bedside commode (with or without assistance).
3	Unable to get to and from toilet or bedside commode but able to use bedpan/urinal independently.
4	Is totally dependent in toileting.

Classic example of an item that is best started from the bottom up to capture the most correct response for the patient.

Be aware *bedside commode* is not introduced until Response 2.

If the patient can get to and from the toilet during the day independently, but uses the commode at night for *convenience*, enter Response 0.

OASIS D Guidance Manual, Chapter 3: K9-K10

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(M1850)	**Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.
0	Able to independently transfer.
1	Able to transfer with minimal human assistance or with use of an assistive device.
2	Able to bear weight and pivot during the transfer process but unable to transfer self.
3	Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
4	Bedfast, unable to transfer but is able to turn and position self in bed.
5	Bedfast, unable to transfer and is unable to turn and position self.

"Minimal human assistance" could include any combination of verbal cueing, environmental set-up, and/or actual hands-on assistance, contributing less than 25% of the total effort required to perform the transfer.

Bedfast refers to being confined to the bed, either per physician restriction or due to a patient's inability to tolerate being out of the bed.

OASIS D Guidance Manual, Chapter 3: K13-K14

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(M1860)	**Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.
0	Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings specifically: needs no human assistance or assistive device.
1	With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
2	Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
3	Able to walk only with the supervision or assistance of another person at all times.
4	Chairfast, unable to ambulate but is able to wheel self independently.
5	Chairfast, unable to ambulate and is unable to wheel self.
6	Bedfast, unable to ambulate or be up in a chair.

Patient who can take one or two steps to complete a transfer, but otherwise unable to ambulate should be considered chairfast.
Patient who does not have a walking device but is clearly not safe walking alone, enter Response 3

OASIS D Guidance Manual, Chapter 3: K15-K16

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Section GG

- Mandated by the IMPACT Act
- Uniform set of data items collected across post-acute settings
- Collected at start of care and other specific time-points
- In home health
  - Some overlap with existing OASIS items
  - Has been incorporated into OASIS data set AND OASIS Guidance Manual
  - Different specifications (of task), scoring, and scoring conventions
  - Free CMS-developed online training has more guidance and case examples

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GG0130. Self-Care

Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s).

Coding:

Safety and **Quality of Performance –** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** – Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance –** Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance –** Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance –** Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance –** Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent –** Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** – Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
☐☐	☐☐	B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
☐☐	☐☐	C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
☐☐	☐☐	F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

Item Intent

This item identifies the patient's ability to perform the listed self-care activities, and discharge goal(s).

Time Points Item(s) Completed

Start of care

Resumption of care

Follow-up

Discharge from agency – not to an inpatient facility

> Note: *This item, GG0130, includes **Performance** assessment and **Discharge Goal(s)** at the SOC/ROC. Refer to sections for instructions, tips and examples for each.*

Response-Specific Instructions – *Performance Assessment* (SOC/ROC, FU and DC)

- Licensed clinicians may assess the patient's performance based on direct observation (preferred) as well as reports from the patient, clinicians, care staff, and/or family.
- When possible, CMS invites a multidisciplinary approach to patient assessment.
- Patients should be allowed to perform activities as independently as possible, as long as they are safe.
  - If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.
  - Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- Patients with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the patient's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).

Response-Specific Instructions – SOC/ROC Performance Assessment

- Code the patient's functional status based on a functional assessment that occurs at or soon after the patient's SOC/ROC. The SOC/ROC function scores are to reflect the patient's SOC/ROC baseline status and are to be based on observation of activities, to the extent possible. When possible, the assessment should occur prior to the start of therapy services to capture the patient's true baseline status. This is because therapy interventions can affect the patient's functional status.

OASIS D Guidance Manual, Chapter 3: - GG5, GG8

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Recognize scoring distinctions

- Levels of assistance
- Set up vs. cueing touch vs. hands-on
- Not attempted- environment
- Not attempted- medical conditions or safety concerns

GG0130. Self-Care

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88. **Not attempted due to medical conditions or safety concerns**

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Recognize task specification differences

- Bathing
  - GG: washing, rinsing and drying (except hair and back), does not include bathing transfer
  - M1830: includes washing only (except hair, hands and face), includes bathing transfer, does not include drying self
- Lower body dressing
  - GG: does not include footwear (separate item)
  - M1820: includes footwear

1. SOC/ROC Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
		A. **Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
		B. **Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
		C. **Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
		E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower
		F. **Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
		G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

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(M1400)	When is the patient dyspneic or noticeably **Short of Breath**?
0	Patient is not short of breath
1	When walking more than 20 feet, climbing stairs
2	With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
3	With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
4	At rest (during day or night)

Patient on continuous O_2, assess patient's shortness of breath while on oxygen (actual use, not just doctor's orders). Patient on intermittent O_2, assess patient's shortness of breath WITHOUT O_2. Consider the time of day the assessment is being conducted, morning when typically their best time of day or Afternoon: low energy, low oxygen time of day?

Consider activities that compromise breathing such as bending, reaching, tugging during ADLs, or standing in a warm moist shower for 20 minutes

OASIS D Guidance Manual, Chapter 3: G1

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(M1242) **Frequency of Pain Interfering** with patient's activity or movement:

0	Patient has no pain
1	Patient has pain that does not interfere with activity or movement
2	Less often than daily
3	Daily, but not constantly
4	All of the time

Standardized pain assessments required in M1240 require patients' perception of pain to be reported on a scale. M1242 assesses the frequency of pain interfering with activity or movement, hence, through observation as well as patient or caregiver report.
Pain interferes with activity when it results in: activity being performed less often than otherwise desired; requires additional assistance performing activity; causes activity to take longer to complete.
Be aware of cues, e.g., patient wearing disposable pants or pads to avoid rushing to the toilet.
Pain that is well controlled with treatment may not interfere with activity or movement at all.

OASIS D Guidance Manual, Chapter 3: E2

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Wounds

Item	Description
M1306	Presence of unhealed pressure ulcer at Stage 2 or higher OR unstageable
M1307	Oldest pressure ulcer (item used at discharge only)
M1311	Current number of pressure ulcers/injuries at each stage
M1322	Current number of Stage 1 pressure injuries
M1324	Stage of most problematic unhealed pressure ulcer/injury that is stageable
M1330	Presence of unhealed stasis ulcer
M1332	Number of observable stasis ulcers
M1334	Status of most problematic stasis ulcer that is observable
M1340	Presence of surgical wound
M1342	Status of most problematic surgical wound that is observable

OASIS D Guidance Manual, Chapter 3: Section F

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Wounds

- Resource for OASIS wound items from WOCN Society
- Use the graphics (WOCN society) and NPUAP guidelines as a resource
- See definitions in OASIS Guidance Manual
- Wounds require direct visualization. Exceptions:
  - Wound is covered by a non-removable dressing (score accordingly).
  - Wound is covered by slough or eschar (score accordingly).
  - Wound is on body surface that cannot be visualized without repositioning and it is not possible with existing resources in the home at time of visit to reposition patient to achieve visualization.
  - Wound is covered by a removable dressing but you do not have competency and/or fresh dressing supplies are not present to redress the wound appropriately.

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Medications & Management

M2001	Did a complete drug regimen review identify potential clinically significant medication issues?
M2003	Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
M2005	**LOOK BACK—not collected at start of care**
M2010	Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
M2016	**LOOK BACK-not collected at start of care**
M2020	Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications.**
M2030	Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

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High Risk Drug Education

- "If agency staff other than the clinician responsible for completing the SOC/ROC OASIS provided education to the patient/caregiver on high-risk medications, this information must be communicated to the clinician responsible for the SOC/ROC OASIS assessment so that the appropriate response for M2010 may be selected. This collaboration does not violate the requirement that the comprehensive patient assessment is the responsibility of and ultimately must be completed by one clinician." (Guidance Manual page L-11)
- 5 day-window for completing Comprehensive Assessment. Even if you did not provide high-risk education, if another clinician did so within the 5 day window, response would be "1" (yes).

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Management of Medications

- M2020 includes oral medications only (prescribed and over-the-counter) only. (Chapter 3: L-13-L-14)
- M2030 includes injectable medications only. Excludes IV medications. (Chapter 3: L-15-L-16)
- Extensive instructions specifying the tasks for each item.
- Specific instructions for:
  - Use of a medication box/organizer.
  - PRN medications.

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Drug Regimen Review 42CFR §484.55(c)(5)

- Based on direct contact with the patient in the home with the current medications present.
- Agencies may implement a "back office" process to have a nurse consult with therapist or review the DRR findings after the visit
- Documentation is over the therapist's signature so any amendments after nurse consult should be made and signed by responsible therapist

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Drug Regimen Review 42CFR §484.55(c)(5)

- A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including:
  - Ineffective drug therapy
  - Significant side effects
  - Significant drug interactions
  - Duplicate drug therapy
  - Noncompliance with drug therapy.

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Review of all medications patient is currently taking

- A comprehensive listing: prescribed or over-the-counter, including herbals
- All administration routes: oral, injectable, inhaled, ophthalmic, topical, transdermal, etc.
- Includes the medication, strength, dosing, route of administration
- Obtained by interview combined with observation and inspection
- Transcribed/entered in the medical record

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Ineffective drug therapy

- Is the medication achieving the desired result?
- Does the patient report symptoms that medication is supposed to address?
- Examples:
  - Patient is taking pain medication but reports breakthrough pain
  - Patient is taking medication for hypertension but blood pressure reported by patient (home monitoring) or directly measured is high.
- Obtained by interview and observation with follow-up questions.
- Limited to medication effectiveness that can be screened or assessed based on patient report or direct observation.

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Significant side effects

- Is the medication producing significant undesirable or non-therapeutic effects?
- Does the patient report symptoms or exhibit signs of significant side effects?
- Examples:
  - Patient reports dizziness when taking a specific medication.
  - Patient reports severe constipation since starting pain medication.
  - Patient reports a rash and itching when using a topical or transdermal medication.
- Obtained by interview and observation with follow-up questions.
- Limited to side effects identified by patient. Determination of "significant" is based on clinician judgment and impact of the effect on the patient.

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Significant drug interactions

- Are there interactions between two or more medications that pose concerns for the patient's health and wellbeing?
- Requires collaboration with another clinician (nurse) and/or drug interaction software, which is integrated into many point-of-care documentation systems
- Therapists are not expected to be familiar with drug interactions
- Patients may identify interactions based on their experience (e.g. "when I take those medications together I get lightheaded.") These reports should be documented as part of the review.

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Duplicate drug therapy

- Are there duplicate medications being administered?
- Are there redundant prescriptions?
- Examples
  - Patient has two bottles of the same medications, labelled identically but filled at two different pharmacies, and is taking medication from both bottles?
  - Patient has two bottles that are labelled with the same medication name. The doses are different or the color of the pills are different. The patient is taking medication from both bottles.
- Obtain by visual inspection of the medication containers.
- Also requires consultation with a nurse and/or use of pharmacy software to identify less obvious duplicates (e.g. generic and brand name, etc.)

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Non-compliance with drug therapy

- Is the patient taking medications at frequencies or doses that differ from what is prescribed/ordered?
- Includes
  - Discrepancies between dosing instruction on label and what patient is taking.
  - Discrepancies between a recent list provided to the patient by a prescriber/provider and what the patient is actually taking.
- Obtained by interview and direct observation/inspection with follow-up questions.
- This aspect of the review is similar to "reconciling" medication orders with the patient's actual medication administration.

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More Resources Re: Medications

- AOTA CE Product (CE Learn): Medication Related OASIS Items & Drug Regimen Review
  - This course is usually $9.95 for members/$14.95 for non-members. Offered at no charge from now until May 24th to support OTs stepping up to do start of care.
- AOTA Official Document: Role of Occupational Therapy in Medication Management

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Next Steps: Review

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Design Visit Strategy

- Documentation (including check boxes) are how you record your findings, but do not have to be how you organize your visit
- Know what information you are seeking and why
- Identify all of your sources of information
- Interview/elicited performance (response to your questions and prompts)
- Spontaneous statements and actions (from patients and caregivers)
- Discharge or after-visit documents in the home
- Medications/equipment in the home
- Cues in the environment (visual/auditory/olfactory)

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Resources

- OASIS D Guidance Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/OASIS-D-Guidance-Manual-final.pdf
- CMS OASIS Manual Page (has D1 Update and Errata): https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual
- WOCN Society OASIS Wound Guidance: https://cdn.ymaws.com/www.wocn.org/resource/resmgr/docs/OASIS-D_Best_Practice_Docume.pdf

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More Resources

- CMS Section GG Training: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Downloads/September_2018_HH_QRP_OASIS-D_Section_GG_without_answers.pdf
- AOTA Position Paper: Role of Occupational Therapy in Medication Management: https://ajot.aota.org/article.aspx?articleid=2652591
- AOTA Products:
  Online CE Medication Related OASIS Items and Drug Regimen Review: https://myaota.aota.org/shop_aota/product/OL4945
  (free until May 24th, reverts to paid CE on 5/25/2020)
- Book/Course: Home Health Care: A Guide for Occupational Therapy Practice: https://myaota.aota.org/shop_aota/product/900436U

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Q & A

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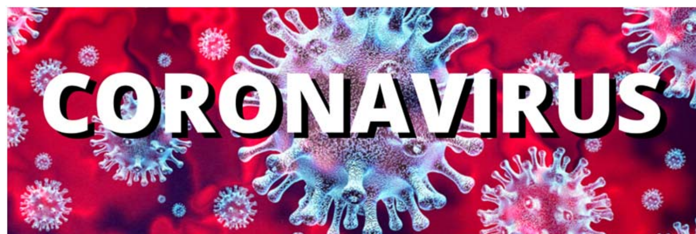
NAHC COVID-19 Information and Resources



nahc.org/covid19
nahc.org/covid19faqs

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Upcoming Events

COVID-19 Waiver Preparation for OTs Opening Cases– Part 2
Tuesday, May 5

COVID-19 Virtual Town Hall
Wednesday, May 6

CARES Act Emergency Funds: How to Achieve Accountability and Compliance Part II
Thursday, May 7, 2020

2020 Financial Management Conference & Expo
July 26-28
Las Vegas, NV

2020 Home Care and Hospice Conference and Expo
October 18-20
Tampa, FL

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