Frequently Asked Questions:

[On-demand webinar] Section GG functional outcomes: How to get the real story

On Tuesday, August 11, 2020, SimpleLTC and QRM (Quality Rehab Management) held a live webinar on Section GG functional outcomes, covering why the outcome measure is the true report card and how SimpleLTC's new Function Score report can help you easily identify negative GG outcomes to address quality care gaps. Based on questions asked during the webinar, industry experts Susan Krall, PT, RAC-CT and Casey Lee, PT, DPT with QRM prepared this follow-up document.

1. What does "GG" stand for?
   GG is an MDS section. Sections are in order A-Z with Section GG: Functional Abilities and Goals located right after Section G: Functional Status

2. Regarding section GG for mobility, if it was not done by PT but they tend to code 1, is this incorrect?
   IDT collaborates on the GG mobility items and determines the code supporting usual performance (UP) in the first and last 3 days. If IDT determines UP is 01 Dependent for a mobility item, then this would be the appropriate code for that specific item. If PT did not complete or observe the resident's mobility during this time-frame then they would not contribute to UP if they did, then they would.

3. How do you code when the therapist states their goal as "CGA or less" for example? Do you code the goal as CGA?
   GG goals and levels selected by IDT are patient-specific and should include input from therapy but are not driven solely by therapy. Select the goal(s) and level(s) based on a realistic level to be achieved by the anticipated discharge date.
   Since rehab functional levels and GG functional levels are written in two different languages, we do recommend educating therapy clinicians on the differences. QRM has included an additional resource to assist with education – please refer to the Therapy Crosswalk – QRM.

4. OT typically does not assist with bathing, but they tend to code it. Is this incorrect?
   Since Section GG standardized, all items should be assessed using the RAI manual directions. There are four codes supporting reasons to not assess an item: 07 Resident refused, 09 Not applicable, 10 Environmental/weather constraints, 88 Not attempted due to safety. If OT does not assess the Shower/bathing item, then they should use one of the 4 not assessed codes describing the reason. All efforts should be made to capture usual performance in bathing from whoever assisted with that task in the observation window and coded appropriately. If no one assessed the patient bathing, then MDS coding would include on of the not assessed options above.

5. If residents are being discharged prior to meeting their goals IE; Managed care residents who are cut by the insurances...should the MDS be coded unplanned?
   Request an anticipated discharge date upon admission of a managed care resident if the MCO did not provide this information and select GG goal(s) and level(s) based on this anticipated date.

6. To prior question: Med A residents under payment plans that drive how long a resident remains in the building, under therapy
   Regardless of payer, discharge planning begins day 1 of the episode and includes determining a realistic discharge date and goals to be achieved within the anticipated time-frame based on patient characteristics and discharge destination/plan.

7. Does Therapy and Nursing complete the forms individually? Then meet and review?
   IDT determines the best way to gather GG UP information prior to the collaborative discussion. The volume of patients to be reviewed may drive how your team decides to approach this. A facility with a high volume of patients within their first and last 3-day windows may benefit from team members completing GG UP Logs individually to bring to the meeting. A facility with a low volume of patients to be discussed might prefer completing the GG UP Log together during the collaborative discussion.

8. Do you need a minimum of one goal from each section?
   No, a discharge goal is required for at least one self-care or mobility item.

9. If patient is not in Rehab services, is collaboration or input from them still required?

Rehab input is always recommended but not required. Reminder, if the patient has rehab minutes anytime during the episode and it's a complete stay, GG outcomes will be calculated and count towards QRP quality measures.

10. Why did we choose 5 goals when only 1 is required?
    Only 1 discharge goal is required, but IDT may determine more than 1 is clinically appropriate for the patient

11. What is the effect on the QRP if we only choice one goal, the minimal required?
    Choosing 1 goal meets the QRP completion compliance requirement.

12. Is there a way to get the excel worksheet on the GG outcomes step-by-step?
    Yes, we can share this tool with attendees – please reach out to QRM directly at http://qrmhealth.com

13. Are the goals selected are in the MDS or part of the rehab document?
    The GG discharge goal(s) selected is on the MDS Initial Medicare Assessment (IMA) PPS 5-day assessment

14. If rehab has started treatment on day 2, should GG be scored before rehab starts?
    Once you see the benefit of intervention in the patient's functional self-care and mobility, capture the level of assistance required prior to that point – for that task noting improvement. Therapy may be involved making great progress on walking on day 2-3 but not addressing toileting hygiene or oral hygiene for example. Score walking prior to the progress the patient exhibited in walking, but keep assessing toileting and oral hygiene (all other required GG items) until you see benefit of intervention in those first 3 days. Nursing may be working on toileting and oral hygiene – so we have to look for benefit of intervention on all GG tasks and do our best to capture true baseline upon admission with "usual" performance in those first 3 days prior to the benefit of intervention.

15. When you discuss not setting a goal in every area, how does this work for MDS coding and submitting when we (nurse case manager/MDS coordinator) are required to?
    Refer to SNF QRP Measure Calculations and Reporting User's Manual V3.0 – Effective: October 1, 2019 *pages 48-49 for the Specifications for a discharge goal (documenting a care plan that includes function): "For the discharge goal, at least one of the items below* ***must*** *have a valid code as specified."*

16. How do you calculate the GG codes for 3 days when they differ over shift and day?

Refer to the RAI Version 3.0 Manual CH 3: MDS Items (GG) page GG-10 for the definition of Usual Performance: "

> A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

17. What if you are higher than the Simple Averages?
    Great job! Your outcomes story is strong and better than average. I still recommend reviewing these outcomes to ensure accuracy but nice work capturing the REAL story!

18. If someone is functionally intact but too old to drive anymore so can't do their own shopping but can cook and take meds, how do you score that patient for functional cognition?
    Could they do their grocery shopping online? If so, I would code as 3 Independent. If not, I would code based on the amount of assistance needed complete the activity.

19. Since nursing doesn't see patients go up and down stairs or car transfers etc., is it OK to use the mobility items from rehab and collaborate with rehab on self-care items?
    Since Section GG standardized, all items should be assessed using the RAI manual directions. There are four codes supporting reasons to not assess an item: 07 Resident refused, 09 Not applicable, 10 Environmental/weather constraints, 88 Not attempted due to safety. If nursing does not attempt an item then they should use one of the 4 not assessed codes describing the reason. This is a great example of why we need your voice and perspective nurses! To clearly demonstrate that tasks like stairs and car transfers are likely unsafe (code 88) for nursing to complete without the patient benefiting from intervention (likely when rehab initiates treatment)

20. How often does rehab and nsg meet when you have admissions and discharges daily?

I recommend meeting daily to review patients in their admission and discharge UP windows.

21. Can you document for the first 3 days scores on a later date like 4-5 days later using the first 3 days scores only? Looking for a workflow.
    Source documentation supporting UP can only be pulled from the first and last 3 days of the stay. The MDS completion schedule has not changed and is based on the ARD.

22. Since aides are so busy often, the OT/PT codes don't match the aides during first 3 days because of time. How do you get around that?

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    A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. **If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.**

23. Would you consider adding an EFI measurement? Improvement in function/Hours of therapy
    I currently review the functional change per day based on Med A LOS and compare it to the total volume of therapy provided across the episode but really like this idea to analyze therapy efficiency and impact on outcomes. Thanks!!

24. How do we do our care plans with the GG?
    The discharge goals are part of the care plan. Determine which goal(s) are clinically appropriate and set level(s) realistically based on patient characteristics and discharge plan.

25. If therapy start treating on day 1, do you still use the 3 days to assess?
    Once you see the benefit of intervention in the patient's functional self-care and mobility, capture the level of assistance required prior to that point – for that task noting improvement. Therapy may be involved making great progress on walking on day 1 but not addressing toileting hygiene or oral hygiene for example. Score walking prior to the

progress the patient exhibited in walking, but keep assessing toileting and oral hygiene (all other required GG items) until you see benefit of intervention in those first 3 days. Nursing may be working on toileting and oral hygiene – so we have to look for benefit of intervention on all GG tasks and do our best to capture true baseline upon admission with "usual" performance in those first 3 days prior to the benefit of intervention.

26. Will rehab be trained on the GG section? They basically pick all the entire goals.
    I strongly recommend that rehab is trained on their role in GG including collaboration on the goals. I do not recommend defaulting to therapy on GG UP scores or selection of the goals.

27. On your form where there are Nursing and Therapy initials... who and when is it filled in?

    Your team can decide how to utilize this form but anyone who contributes to the story is able to initial. GG UP is collected in the first and last 3 days.

28. For GG goal setting, my understanding is that we can set a goal to maintain, improve or anticipate a decline. Is that not the case?

    You are correct! Anticipating maintenance and/or a decline is a great way to demonstrate our skilled clinical decision making. If this is the case, all goals would be met as we anticipated the decline or plateau. Sadly, I just don't see this clinical decision making reflected in our industry numbers yet. When I initially audit a group, I typically observe < 50% goals met (this improves immediately once the team is made aware of the issue!). I'm looking forward to seeing what the Simple Community averages are when this portion of the Function Scores Report gets built out!

Helpful resources

- IDT GG UP Log - QRM
- Therapy Crosswalk - QRM