
# Shipwrecked or Smooth Sailing:
## How to stay on course with GG and PDPM

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1. **Is there a source regarding determining the expected discharge function?**
   A: SimpleLTC has created reporting on "expected discharge function". Stay tuned.

2. **Are we using the first 3 days of ARD period for GG on OBRA assessment also?**
   A: OBRA assessment GG is ARD and 2 days prior.

3. **Thoughts on GG window if an early ARD is used?**
   A: Admission ARD GG is always the first 3 days of the stay prior to the benefit of intervention.

4. **Since nurses do not take patients up and down stairs and car transfer, how do they code those?**
   A: If therapy did assessment during the first 3 days, then utilize therapy for these items. If no one assessed, then select the reason why when coding - do NOT dash.

5. **Do you recommend therapy GG levels be included in determining the usual performance on admission? Frequently the therapists provide interventions during their evaluations, and this can be difficult to then code GG accurately.**
   A: Certainly, include feedback from all caregivers including therapy when taking into consideration "usual" performance -however remember to stop gathering performance levels once the "benefit from interventions are noted for a task."

6. **QRP states we can choose just one goal. What are your thoughts on this?**
   A: That is true however, for overall IDT care planning, it would make sense to me to address the goals that are most critical to the patient for a safe transition to the next level of care.

7. **So, you are saying regardless of if the nursing home is SNF or intermediate we must have the MDS done by day 3 of admission?**
   A: MDS does not have to be done by day 3 of admission. GG information gathering and determination of usual performance only includes the first 3 days of the stay.

8. **Are we able to see CMS' expected outcome the algorithm creates?**
   A: SimpleLTC has created that reporting. Stay tuned.

9. **Does GG need to be signed on day three? I sign the next day since the window closes at midnight of day three. Is this wrong?**
   A: Best practice is to get it signed by day 3 based on auditors' responses.

10. **Where are the CNAs recording this information?**
    A: Great question. For now C.N.A's are typically being questioned by nurses who often have the questions built into UDA's. Some also have flow sheets in use. There are trackers available through AAPACN as well.

11. **Therapy and nursing usually don't match, so how do you get the usual performance?**
    A: Take into consideration "usual" -how many times does the therapist witness activities coded vs direct caregivers, patients, and families? I would weigh heavier input as to what happens throughout the 24 hours in a day vs time spent with the therapist.

12. **Can we use nursing and therapy GG information to answer GG on the MDS, like an average of both?**
    A: Yes - whatever best reflects usual. If a patient is only walking in therapy for example.

13. **What tools do you use to capture usual performance from all the GG assessments?**
    A: AAPACN's tool for example has a tracker allowing for multiple shifts a day to have input per GG item so the team can determine 'usual' based on # of times and levels are recorded.

14. **The RAI says if there is no answer, they score a Zero--I cannot understand how auditors can score them as independent--what source are they taking this from?**
    A: We were referring to the lack of timely signed and dated assessment of resident usual performance to back up the values. However, GG scoring allows for all scenarios if the activity is not performed: 7: Pt Refused, 09: Not applicable, 10: Not Attempted due to environment, 88: Not attempted due to medical conditions/ safety concerns.

15. **Lack and signed MDS assessments lead to audit?**
    A: Under scrutiny during an audit - lack of documentation to back up and a signed GG final assessment of GG can lead to financial loss during an audit.

16. **We are appealing to the ALJ for a takeback from a Medicare Advantage insurance for Section GG?**
    A: Make certain you have a valid assessment of usual performance.

17. **What is the plan if we don't have all documentation by the 3rd day to complete the IDT collaboration when nurses only do the designee observation? Therapy may not get in by the 3rd day and most questions come from their eval. Medicare and managed care folks.**
    A: If a task was not assessed in the 3-day window then you'll have to select one of the options as to why not. Ex: if nursing didn't walk the patient and therapy wasn't in - why didn't they try walking? Safety Concerns may be why which would be indicated with an 88 code.

18. **How do you determine the most accurate way to code GG when documentation between disciplines conflict?**
    A: Look for the most often performed level during the window.

19. **When you attach multiple Functional Abilities Assessments observations to the MDS assessment-on matrix is already averaging or how do you compare what is the most accurate from multiple GGs insight?**
    A: IDT meeting to review and make the determination is best practice (Refer to RAI manual for additional guidance).

20. **For GG supporting documentation, we have the following --therapy eval/notes; Nurses complete assessment for 1st three days regarding resident's performance/help needed with ADLs; and CNAs chart once per shift on ADL assistance required. If this documentation is accurate, does this suffice as that "supporting documentation"?**
    A: As long as it is in the EMR for access during an audit, but you still need an assessment determining the usual performance in the EMR signed and dated.

21. **Our therapy department usually does the GG so what assessment does nursing need to do for GG. Is there a specific assessment to use or do they just need to be using the GG questions in the MDS?**
    A: Follow the instructions and guidance in the RAI manual for each question in section GG.

22. **How often are IDT meetings to review the results from GG assessments?**
    A: Daily would be ideal during the 3-day window. No later than day 3.

23. **According to my understanding GG usually performs 3 days not to be done day 2 and 3 if therapy intervention done on day 2?**
    A: RAI instructions note that information is to be gathered and coded prior to the "benefit of intervention". The IDT should be able to determine when the level captured is prior to the benefit of intervention.

24. **For Fri admits - can we finalize scores and documentation on Monday as long as we only use Fri, Sat, and Sun documentation??**
    A: Documentation should be gathered each day. Ideally the task would be assigned to someone on the weekend.

25. **With the removal of Section G, do you foresee the ADL documentation being removed from Point of Care in the EMR and those questions replaced with the GG items?**
    A: Depending upon the need for Section G by the Medicaid or Managed Care models in place. If no other entity (Medicaid through OSA item set) is taking into consideration Section G items, there would be no need to gather that information since it does NOT correlate to GG coding.

26. **I am reading/hearing a lot of "chatter" about "helpers", "CNAs(NACs)" will be given more responsibilities/will be allowed to document more and that there is a recommendation to have dedicated "helpers" that only focus on documenting GG. Any thoughts?**
    A: I have heard of restorative aides being asked to take on responsibility of gathering GG information from caregivers, patients, and families. The assessment of Usual Performance must be completed by the appropriate person as spelled out in the RAI manual.

27. **If speech is picking up a patient for Dysphagia is this not supporting documentation to support a swallowing disorder?**
    A: NO - the swallowing disorder only comes from Section K answers in the MDS and documentation to specifically support coughing/choking/pain with swallow/ pocketing/loss of food or fluids.

28. **For dysphagia what is the code that qualifies in I8000?**
    A: Must refer to the ICD-10 mapping tool.

29. **What if the resident is NPO and is G-tube dependent?**
    A: Still assess items in Section K. They may be choking on their saliva and drooling for example.

30. **For ST capture they need to be within 3 days as well?**
    A: All items driving the ST component must be captured within the assessment window - not after the ARD.

31. **Is an active dysphagia dx adequate to check yes in section K if we don't have specific documentation (other than the dx) in the 7-day window?**
    A: No. Definitely make certain that Dx is in I8000 AND document problems specific to Section K questions so that Section K can be checked off appropriately with the backup.

32. **Does resident have to have a dx of COPD etc. to capture SOB?**
    A: Document assessment of SOB no matter what but for Special Care High SOB alone won't qualify.

33. **We have a GG worksheet discussed as an IDT that is included in the resident chart - is it sufficient to document on this worksheet any observations of SOB? (The nursing supervisor is part of the IDT discussion)?**
    A: As long as it is in the EMR as documented assessment of SOB so the MDS coordinator can catch it and claim it that should suffice.

34. **Where is the provider form for DX?**
    A: In the references - it's the Physician Query form.

35. **Can you comment on "SOB". We have so many nurses who say, "they didn't c/o SOB". "I asked them" or "that is their baseline". I try to educate them that it's ABNORMALLY "Normal" for them, but it is STILL ABNORMAL. Your thoughts?**
    A: Patients can be questioned as to whether they experience SOB when flat and/or if they are never wanting to lay flat - ask why. Don't wait for a c/o, it should be assessed. RAI has helpful guidance.

36. **Is it safe to say that if patient is on mechanically altered diet their section K should reflect the deficit as well?**
    A: Depends on any observed signs and symptoms experienced during the look back period. If they were placed on Mech Altered diet after admitting and problems were noted and it was during the assessment window, those problems of coughing/choking/pain etc. should be documented in noted in Section K. Definitely should be scrutinized if nothing is indicated in Section K.

37. **In terms of Medicaid switching to PDPM, to promote efficiency, would it be appropriate to create and use a GG assessment tool that only observe/assess for the items that populate function score?**
    A: Diligence in assuring documentation and a thorough assessment during the assessment window would be critical.

38. **Section GG capture is for the full 3 days so I was completing the assessment on day 4 but I was told that this was outside of the window but how do you capture the full 3 days if it is completed it on day 3 as I was instructed?**
    A: It is a tricky situation but one that is being interpreted by auditors strictly as needing to see the documentation in the first 3 days.

39. **How does everyone get the nursing staff to complete their documentation on the GG forms for that 3-day period every shift?**
    A: Question of the decade! Leadership and accountability plus making it as routine and simple of a process as possible.

40. **I know we are to have no dashes but what if you have a resident that refuses to be weighed every month, what is the correct thing to do?**
    A: Continue different approaches to gather the weight and document every time. In GG there are optional codes to cover refusals.

41. **Do you recommend any specific resource to finding out what states are changing their Medicaid Reimbursement model?**
    A: I have been re-directed to state level RAI coordinators. Also state associations are helpful in sending updates. We have a running tracker of what we're learning.

42. **So, what are the changes for GG in October?**
    A: There are only a few questions that have been tweaked but the biggest issue is that it will be required on all assessments. Admit/ IPA/ OBRA / DC.

43. **Does the GG form used to collect data have to be signed and locked by day 3? Is it sufficient to document in the form that the data was collected from day 1-3?**
    A: We have seen auditors looking for signature by day 3.

44. **Any tips for successful capture of SOB lying flat??**
    A: Interview and observe or lie the patient flat and assess breathing for SOB. Also you can ask therapy.

45. **Just to clarify. I know the primary diagnosis in I0020 has to also be in I8000. If the patient has a diagnosis of depression, diabetes, hypothyroid, hypertension and I check it on the MDS, do I also need place those diagnoses in I8000?**
    A: YES - just best practice to cover your bases to make certain it will be picked up for co-morbidities, nursing and NTA credit.

46. **Will IDT progress note within the look back period be enough documentation for any missing documentation of the Gs and GGs and swallowing?**
    A: GG is in the first 3 days only for admissions and ARD with 2 days prior for other assessments. G and Swallowing documentation is gathered during the entire assessment window.

47. **What if the resident will not allow the bed to be put flat, because it will cause them to be short of breath?**
A: Document that clearly and interview them with documented responses, then capture.

48. **Can MDS nurse document when during interview & direct observation for swallowing problem (Section K) during meal?**
A: Yes -as long as it is documented.

49. **Finding that training CNA GG is hard and confusing as in PA we still need G for OSA. So I'm unsure what PCC / POC plan is to get POC up to date with GG over G in the near future.**
A: I have not heard of their plans. It has been confusing for everyone.

50. **For OBRA GG... the collaboration form would have to be signed after the ARD unlike the 5 day?**
A: OBRA GG window is the ARD and 2 days prior so I would say sign on the ARD (day 3 of assessment).

51. **Is Family and Staff interview in the first 3 days or prior to intervention is good enough to establish the GG?**
A: Make certain it is documented - not sure that would be a true representation of your caregivers support.

52. **Thank You for all the information. I do long term patients, so these changes and GG section are confusing and do not pertain to these types of patients. How is GG going to be for them moving forward?**
A: GG will be gathered on long term patients beginning Oct 1, 2023. G will be removed from all item sets with the exception of the optional OSA item set if utilized in your state.

53. **Is the GG coding period the first three days of the Medicare stay or only until the ARD? (If the ARD is before day 3)?**
A: If the ARD is prior to day 3 - GG would need to be gathered and documented on the ARD and day(s) prior.

54. **Can you please explain ARD and 2 days vs Admission first 3 days prior?**
A: GG is gathered for a 3-day period. First 3 days of admission. For all other item sets it's the ARD and 2 days prior.

55. **Can we use the CNA flowsheets for section GG proof as they are signed by the CNA's?**
A: As long as this is part of the EMR and can be utilized during an audit and the information is assessed by an appropriate team member per RAI manual instructions.

56. **If resident is NPO and receives tube feedings due to swallowing problem, do you code problem with swallowing in sec. K?**
    A: Yes - code whatever swallowing problem was noted during the assessment window even if only one time.

57. **Do you have additional information to share on the G replacement QM changes at this time?**
    A: Nothing is available yet as of the CMS Open Door Forum on 4/13/23.

58. **Can we use a BIMS that was collected in the evening when deficits are present even if alert and oriented during the day?**
    A: I would default to the RAI manual for any additional guidance on that, but it certainly should be taken into consideration.

59. **So how do you average the section GG with therapy and nursing? The patients sometimes have different functional mobility throughout the day needing min A to max A.**
    A: All we can do is look for the most frequent level of help recorded and code that. Thus, the importance of gathering throughout every day during the 3-day window from all caregivers, patients and families.

60. **If someone has COPD should you also use respiratory failure for a DX?**
    A: Not without physician documentation.