2026 Annual PADONA Conference

GG Done Right: Building a Process that Works

Objectives

- Review the components and coding criteria for GG
- Discuss key IDT members for the GG team
- Delve into best practices with a GG process development

Section GG

Self-Care and Mobility- Steps for Assessment

Assess the resident's self-care and mobility performance based on direct observation, incorporating the resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period.

CMS anticipates that an interdisciplinary team of clinicians is involved in assessing the resident during the assessment period.

Self-Care and Mobility Observation Periods

Admission

- OBRA-First 3 days of the stay starting with A1600
- PPS 5d –First 3 days of the Medicare Part A stay starting with A2400

OBRA/Interim

- OBRA-required assessment other than an Admission assessment (i.e., A0310A = 02 – 06), the assessment period is the ARD plus 2 previous calendar days.
- IPA--is the last 3 days (i.e., the ARD plus 2 previous calendar days).

Discharge

- Medicare Part A PPS discharge assessment period is the End Date of Most Recent Medicare Stay (A2400C) plus 2 previous calendar days.
- Discharge assessments, the assessment period is A2000, Discharge Date plus 2 previous calendar days.

“Usual Performance”

- 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.*

Self-Care and Mobility Coding Tips

Assessment of the GG self-care and mobility items is based on the resident's ability to complete the activity with or without assistance and/or a device. This is true regardless of whether or not the activity is being/will be routinely performed (e.g., walking might be assessed for a resident who did/does/will use a wheelchair as their primary mode of mobility, stair activities might be assessed for a resident not routinely accessing stairs).

Self-Care and Mobility-Performance Coding Tips

General coding tips

- The assessment timeframe is up to 3 calendar days based on the target date. During the assessment timeframe, some activities may be performed by the resident multiple times, whereas other activities may only occur once.
- A dash (–) indicates “No information.” CMS expects dash use to be a rare occurrence.
- CMS does not provide an exhaustive list of assistive devices that may be used when coding self-care and mobility performance. Clinical assessments may include any device or equipment that the resident can use to allow them to safely complete the activity as independently as possible.

Self-Care and Mobility-Performance Coding Tips

Continued:

- Do not code self-care and mobility activities with use of a device that is restricted to resident use during therapy sessions (e.g., parallel bars, exoskeleton, or overhead track and harness systems).

Coding tips for coding the resident's usual performance

- If two or more helpers are required to assist the resident in completing the activity, code as 01, Dependent.

6-Point Coding Scale

- 06 Independent
- 05 Setup or clean up assist
- 04 Supervision or touching assist
- 03 Partial/moderate assist
- 02 Substantial/maximal assist
- 01 Dependent

Activity Not Attempted Codes

- 07 Resident refused
- 09 Not applicable-Not attempted and did not perform this activity prior
- 10 Not attempted due to environmental limitations
- 88 Not attempted due to medical condition or safety concerns

START DECISION TREE HERE

Question	If YES
Does the patient/resident complete the activity – with or without assistive devices – by themself and with no assistance (physical, verbal/nonverbal cueing, setup/clean-up)?	**06 – Independent**
NO ↓ Does the patient/resident need only setup/clean-up assistance from one helper?	**05 – Setup/Clean-up Assistance**
NO ↓ Does the patient/resident need only verbal/nonverbal cueing or steadying/touching/ contact guard assistance from one helper?	**04 – Supervision/touching assistance**
NO ↓ Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing less than half of the effort?	**03 – Partial/moderate assistance**
NO ↓ Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing more than half of the effort?	**02 – Substantial/maximal assistance**
NO ↓ Does the helper provide all the effort to complete the activity OR is the assistance of 2 or more helpers required to complete activity?	**01 – Dependent**

Self-Care and Mobility Items

Self-Care

Eating

Oral hygiene

Toilet hygiene

Shower/bathe self

Upper body dressing

Lower body dressing

Putting on/taking off footwear

Personal hygiene

Mobility

Roll left to right

Sit to lying

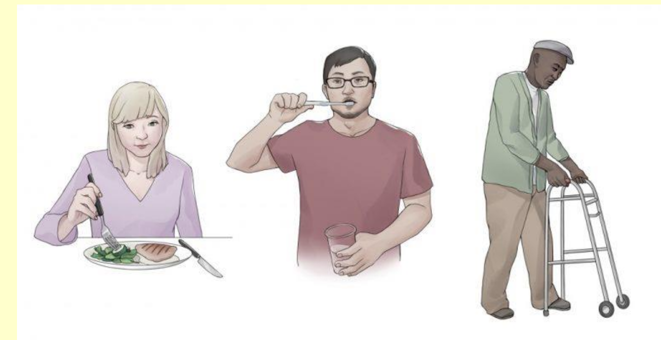
Lying to sitting on side of bed

Chair to bed/chair transfers

Toilet transfers

Tub/shower transfers

Car transfers



Walk 10ft, 50ft with 2 turns, 150ft
Walk 10ft uneven surfaces
Steps 1 step, 4 steps 12 steps
Picking Up an object
Wheelchair

What does GG coding effect?

- **Resident assessments and planning for care**
- **Quality Measures**
  - MDS 3.0 QMs
  - SNF QRP
  - SNF VBP
  - Five Star
- **Audits**
  - Medicare
  - Medicaid
  - Managed Care
- **Survey deficiencies**
  - Resident assessments
  - Care plans
  - Quality of life/quality of care
- **Reimbursement**
  - Medicare
  - Medicaid
  - HMO/Med Advantage

The GG Team

Team Players

- MDS Coordinator/NAC
- DNS/ADON/Clinical Nurse Managers
- Therapy
- Nurses
- CNAs

Team Documentation

- Resident interviews
- Observations
- Direct care staff interviews
- Nurse aid documentation - point of care, kiosk
- Nurse functional assessments
- Therapy progress notes and evaluations
- IDT collaboration progress note and/or assessment

Section GG

#	Topic	Question	Response
53	Section GG Documentation	What will the expectation be for completion of a tool (i.e., GG), for daily documentation of functional status come October? I.e., will it be expected that GG is completed daily to assist in detecting resident changes and having documentation of daily functional status? GG is time consuming to have to use as a daily tool. Trying to process what should be best practice.	Chapter 1, under 1.3 Completion of the MDS RAI 3.0 v1.18.11 User's Manual, states that the RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that: (1) the assessment accurately reflects the resident's status (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts. Nursing homes are left to determine: (1) who should participate in the assessment process (2) how the assessment process is completed (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual. While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including to code the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements.
57	3-Day Assessment Window for Section GG	Are we allowed to establish and document the final "usual" functional performance for GG AFTER the 3 days documentation?	Completion of Section GG of the MDS (i.e., coding determination) does not need to occur within the 3-day assessment window, but it is expected to be based on assessment(s) completed within the 3-day assessment window. The Interdisciplinary Team (IDT) can assimilate the data to determine "usual performance" after day 3 as long as they only utilize data/information from the 3-day assessment window.

Strategies on Building a GG Process

Team GG Process

- Staff training/education
- Policies and procedures
- Functional status documentation-may be multiple sources
- IDT Collaboration
- EMR capabilities for documentation
- MDS coding/completion
- Dashes (-)
- Ongoing monitoring and evaluation

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About CMS Newsroom Data & Research

Medicare Medicaid/CHIP Marketplace & Private Insurance Initiatives Training & Education

Medicare > Quality > Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) > Quality Reporting Program > SNF Quality Reporting Program Training

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)

Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Training

Section GG Training Materials

Section GG -Web-Based Training Series

This web-based training series is designed to be used on demand anywhere you can access a browser and includes interactive exercises to test your knowledge related to the assessment and coding of Section GG items. This training series consists of five courses:

- Course 1: Section GG Data Accuracy and Quality Measures.
- Course 2: Prior Functioning and Prior Device Use Items.
- Course 3: Accurate Coding for GG0130 and GG0170 Items.
- Course 4: Understanding Admission and Discharge Performance for GG0130: Self-Care Items.
- Course 5: Understanding Admission and Discharge Performance for GG0170: Mobility Items.

(Continued)

- GG0110. Prior Device Use with Information from Multiple Sources. (3:58)
- GG0130A. Eating. (6:19)
- GG0130B. Oral Hygiene (4:25)
- GG0170C. Lying to Sitting on Side of Bed (4:31)
- GG0130H. Putting on/taking off footwear. (6:25)
- GG0170L. Walking 10 feet on uneven surfaces. (5:52)
- GG1070P. Picking up object. (5:49)
- Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility. (11:56)

Training and Education

- Focus on each self-care and mobility item separately
- Observe staff assistance with resident's functional status and discuss the assistance provided for documentation
- Document
  - Observations
  - Resident self-reports/interviews
  - Family interviews
  - Staff interviews
  - Reports qualified clinicians

Documentation

Facility policies and procedures for GG documentation

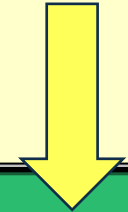
Who? When? Where?

- Who will document-CNAs, Nurses, Therapy, IDT
- When to document-daily, every shift, evaluations
- Where to document-Kiosk, point of care, tasks, functional assessments, nursing and therapy progress notes, therapy evaluations

IDT Collaboration Documentation

- Team meeting
- Review the 3-day observation/look back period documentation from all sources
- Identify as a team the resident's "usual performance" for each self-care and mobility task
- Document the IDT's determination

IDT Collaboration Documentation Example



Functional Ability Items: SELF-CARE (GG0130)	Performance Codes			
	Day 1	Day 2	Day 3	IDT Determined Usual Performance
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 resident.	5	5	6	5
Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.	5	5	4	5
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.	4	3	3	3
Shower/bathe self: The ability to bathe self, including washing, rinsing, and drying self (excluding washing of back and hair). Does not include transferring in/out of tub/shower.	2	2	1	2

Monitoring GG Process

- MDS audits for GG accuracy
- Monitor GG documentation
- Review IDT collaboration documentation
- Quality Measures
- QAPI/QAA

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About CMS Newsroom Data & Research

Medicare Medicaid/CHIP Marketplace & Private Insurance Initiatives Training & Education

Medicare > Provider Enrollment and Certification > QAPI > QAPI Resources

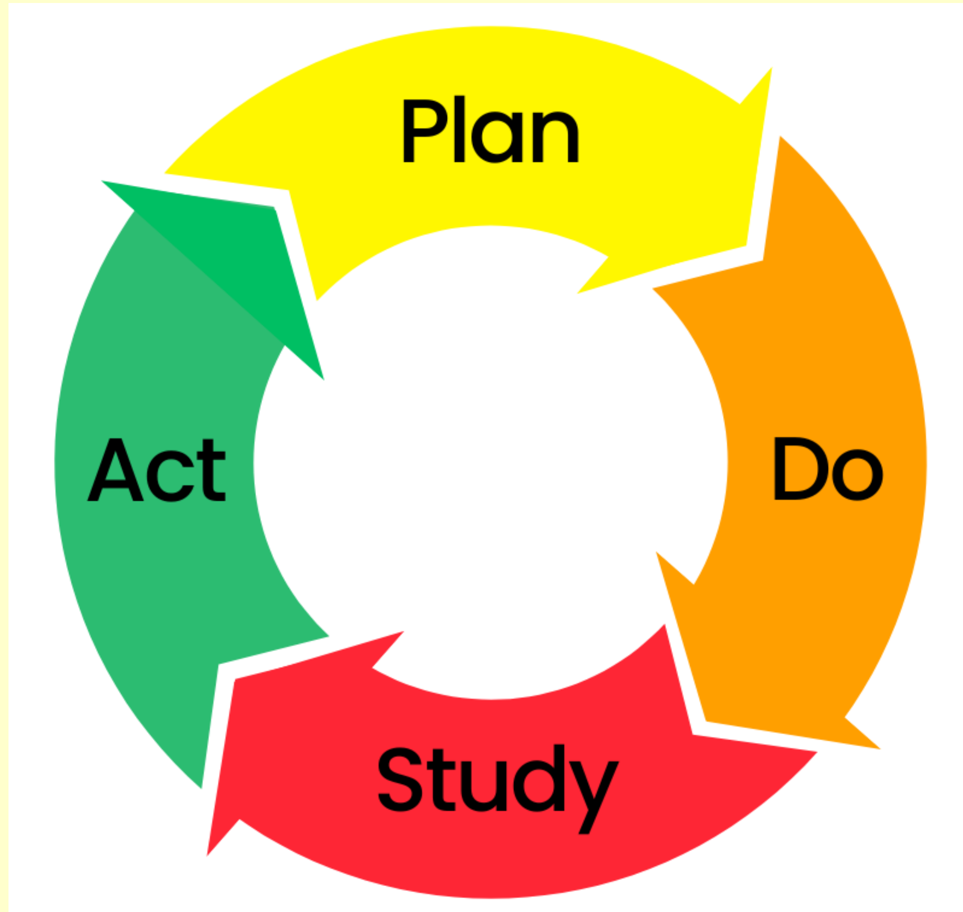
QAPI Resources

CMS strives to provide nursing home providers with access to resources (materials or websites) to support QAPI implementation. Use of these resources is not mandated by CMS for regulatory compliance nor will their use ensure regulatory compliance.

Guides to Quality

Implementing Change in Long-Term Care: A Practical Guide to Transformation
This resource was prepared by the Pioneer Network with a grant from the Commonwealth Fund. Although it deals with implementing culture change (not QAPI), it is a good resource on the change process. Click here to access Implementing Change in Long Term Care - Opens in a new window .

PDSA – When to use?



- Initiating a new improvement project
- Designing or enhancing a new process or care delivery system
- Comprehensive review of repetitive work process
- Planning data collection and analysis in order to verify and prioritize problems or root causes
- Implementing any change
- Working towards goal of continuous improvement

Example – Functional Abilities Documentation

Plan	Do	Study	Act
The facility will develop a process for functional abilities documentation. The IDT (DON, NAC, and clinical managers) will incorporate documentation of functional abilities daily.	Daily documentation schedules will be monitored by the DON, NAC, and clinical managers for completion.	Analysis of the documentation of functional abilities determined that it was completed 75% of the time. Staff education will be ongoing for successful completion of documentation.	Facility policy will be created for daily documentation of a resident’s functional abilities. IDT collaboration documentation will be implemented as well for determination of the resident usual performance.

QAPI Prioritization Worksheet for Performance Improvement Projects- Example

POTENTIAL AREAS FOR IMPROVEMENT Consider areas identified through: Dashboard(s) Feedback from staff, families, residents, other Incidents, near misses, unsafe conditions Survey deficiencies	PREVALENCE The frequency at which this issue arises in our organization.	RISK The level to which this issue poses a risk to the well-being of our residents.	COST The cost incurred by our organization each time this issue occurs.	RELEVANCE The extent to which addressing this issue would affect resident quality of life and/or quality of care.	RESPONSIVENESS The likelihood an initiative on this issue would address a need expressed by residents, family and/or staff.	FEASIBILITY The ability of our organization to implement a PIP on this issue, given current resources.	CONTINUITY The level to which an initiative on this issue would support our organizational goals and priorities.	TOTAL SCORE TALLY
MDS Data Elements	3	5	5	5	3	4	4	29
GG Documentation	5	5	5	4	3	5	5	32
QM Monitoring	3	3	3	3	3	2	2	19

Action Plan

Topic: MDS GG Coding Goal: Accurate coding of MDS section GG			
What Actions Do We Need to Take?	**Who is Responsible?**	**Date to be Completed**	**Date Action Completed**
Internal audit on MDS section GG	Audit team assigned- NAC, DNS, and Clinical Managers	6/1/2026	9/1/2026

Worksheet to Create a Performance Improvement Project Charter

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:
Example: Reduction in use of position change alarms

Problem to be solved:
Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.

Background leading up to the need for this project:
Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.
[Tip: Reference specific background documents, as needed.]

The goal(s) for this project:
Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.
[Tip: See Goal Setting Worksheet]

Scope—the boundary that tells where the project begins and ends.
The project scope **includes:**
Example: Use of position change alarms on XX unit.

PROJECT APPROACH

Recommended Project Time Table:

PROJECT PHASE	START DATE	END DATE
Initiation: Project charter developed and approved		
Planning: Specific tasks and processes to achieve goals defined		
Implementation: Project carried out		
Monitoring: Project progress observed and results documented		
Closing: Project brought to a close and summary report written		

Project Team and Responsibilities:

TITLE	ROLE	PERSON ASSIGNED
Project Sponsor	Provide overall direction and oversee financing for the project	
Project Director	Coordinate, organize and direct all activities of the project team	
Project Manager	Manage day-to-day project operations, including collecting and displaying data from the project	
Team members*		

Barriers

What could get in the way of success?	What could you do about this?
Example: A resident could fall and staff could automatically blame the lack of an alarm.	*Example:* Educate staff on the lack of relationship between alarms and falls; collect data on removal of one alarm at a time.
Example: Staff complaints of need for additional staff to watch everyone if alarms are removed.	*Example:* Focus on anticipation of resident needs, and assess if additional hands-on-deck are needed during busy times on unit.

PROJECT APPROVAL

The signatures of the people below relay an understanding and approval of the purpose and approach to this project. By signing this document you agree to establish this document as the formal Project Charter and sanction work to begin on the project as described within.

TITLE	NAME	SIGNATURE	DATE
Administrator			
Project Sponsor			
Project Director*			
Project Manager*			

*May not always have both roles.

Performance Improvement Project Charter

Performance Improvement Project (PIP) Inventory

Directions: Use this template for high level tracking of all PIPs occurring within your organization. This document may be particularly useful for leadership, surveyors, or others responsible for overall monitoring of the program. Consider updating the status column on a regular basis; e.g., quarterly. This may be helpful to bring to the QAPI team meetings, to review all PIPs that the organization has currently underway, to identify if the PIPs are moving along, if any have stalled, etc.

Date(s) of Review: ______________

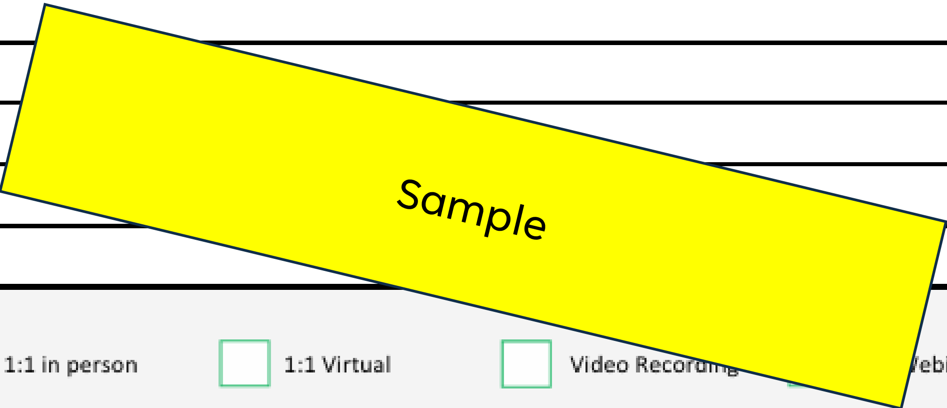
Project Name	**Start Date**	**Current Phase** *Initiation, Planning. Implementation, Monitoring, Closing*	**Purpose** *What is the reason for conducting this project?*	**Change(s) Initiated** *What actions have been put into place?*	**Indicators/Measures** *Which data are being tracked to show improvement?*	**Status** *What are the indicator/measure results as compared to goals or thresholds? Have any unintended consequences or barriers been identified? How are they being addressed?*
Review GG documentation	7/1/26	Auditing of GG documentation and process	Documentation for Accuracy and process	Nursing daily documentation	Nurse assessments and Nurse aid documentation	Missing doc, assessments

MDS Training Competency Tool

Name of Training Planner:	Training Deadline:

Objectives

1	The learner will
2	The learner will
3	The learner will
4	The learner will
5	The learner will



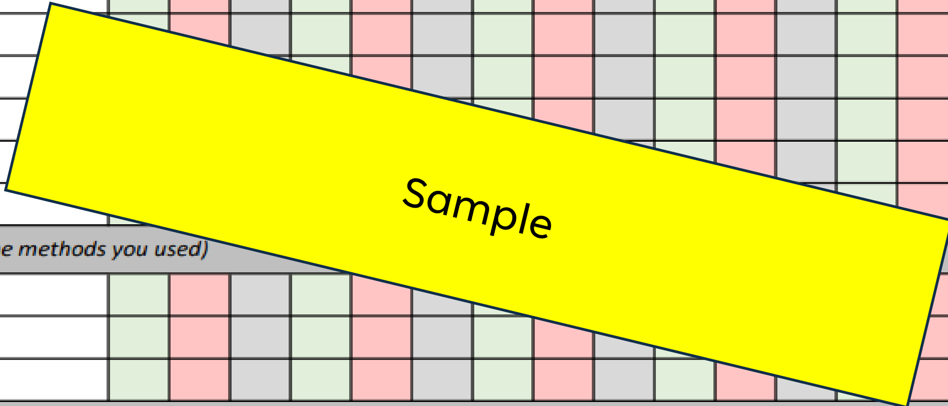
Method of Delivery ☐ 1:1 in person ☐ 1:1 Virtual ☐ Video Record[illegible] ☐ [illegible]ebinar ☐ Other

Evaluation Technique	Verbal Test	Written test	Formal Audit	Statement of Understanding	Other

MDS Section	Item (if applicable)	Reviewed RAI Coding Criteria	Training Completed by	Date Completed	Employee Trained

Regulatory Change Implementation Log

TOPIC: MDS GG Coding	Initial			3 months			6 months			Annual			As Needed			Comments
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	
Systematic System Review – *review internal processes and add/update/create as needed*																
Internal Policy/Procedures																
Facility Tools																
Staff Training/Competency*																
Orientation																
Job Descriptions																
Employee Evaluations																
Other *(please specifiy)*																
Internal Audit *(check any/all of the methods you used)*																
Record Review																
Observation																
Interviews																
Evaluation and Monitoring																
Action Plan *(if needed)*																
PIP *(if needed)*																
QAPI/QAA* *(if needed)*																
Responsible Party																
Completion Date																



**MDS Consultants offers this monitoring tool*

To tally QAPI QAA compliance: **[# of items marked "yes" ÷ total number of possible items (not including items marked N/A)] x 100 = % compliant**

Leaders in MDS Completion since 2008 | MDS Consultants | Call us to help you: (954) 637-3235

QAPI QAA Log

QAPI Topic	Section	Review/Audit Completed			Action Plan Completed			PIP Completed			Monitoring Set Up			Responsible Party	Completion Date
		Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A		

Sample

To tally QAPI QAA compliance: [# of items marked "yes" ÷ total number of possible items (not including items marked N/A)] x 100 = % compliant

References

RAI Manual

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

SNF QRP (Quality Reporting Program) Training Program

https://www.cms.gov/medicare/quality/snf-quality-reporting-program/training

Participant Questions from the SKILLED NURSING FACILITY MDS 3.0 RAI v1.18.11 GUIDANCE TRAINING PROGRAM On June 21, 2023

https://www.cms.gov/files/document/2023augustsnfguidancetrainingprogramqa.pdf

References

Nursing Homes | CMS

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes

State Operations Manual (SOP) Appendix PP

https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

QAPI Resources

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapiresources

Completion | Training | Compliance

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