



Pennsylvania

**Department of Human Services**

Office of Long-Term Living

# interRAI Version 10 Training Case Study Guide



talent ▶ direction ▶ teamwork

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## Introduction

This guide is a companion to the interRAI Version 10 training. The guide is intended to assist assessors in applying the knowledge from the online course. The examples and case studies in this guide are taken from feedback from the network of assessors and service coordinators.

Please note that this is not meant to be a replacement for the training. It is a supplement to the self-directed Version 10 training. This is not a policy document. This is not a manual. It is a set of case studies to assist Pennsylvania's OLTL assessors (AWP and MCO) in applying the information, definitions and processes required to determine eligibility for Pennsylvania's programs.

There are also examples and case studies in the interRAI Version 10 manual developed specifically for Pennsylvania. Please ensure that you have access to that documentation. It is a user manual developed by interRAI and available for purchase on their website. Also ensure that you have read and studied the associated OLTL eligibility bulletins.

**Coding definitions are taken directly from the interRAI Version 10 Manual, Pennsylvania State Edition.** The manual is copyrighted material.

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## Section A. Identification

### Living Arrangements

**Mr. Jones** is a man in his early thirties. He was injured in a traffic incident and is paralyzed from the chest down.

After his initial hospital stay, he was transferred to a nursing facility for long-term care. He has used all of his private resources and insurance.

He now seeks financial support through the Community Health Choices (CHC) waiver program. An Aging Well PA assessor is sent to perform the initial eligibility determination.

Mr. Jones is not happy with his living situation. His son becomes despondent when visiting him for many reasons. He is physically deteriorating and has no control over his life.

He expresses concerns that he will die if he stays in his current situation.

**Mrs. Smith** is an 80-year-old woman whose chronic conditions require support that she can no longer afford.

She seeks assistance through the CHC waiver program.

She lives in an apartment building in a small city. She expresses concerns for her safety. There is no elevator, and she is on the fourth floor.

She can no longer manage the stairs but would still like to get out of her apartment. She is fearful daily.

These concerns should be noted in the assessment. Her living arrangement is having a direct effect on her ability to live fully. Living arrangements would be addressed in the person-centered service plan. It does not affect eligibility.

## Section B Cognition

Cognition includes Making Decisions, Memory/Recall, Disordered Thinking, and Acute Changes. The instructions for completing these assessments are in the interRAI Manual in Section c.

### Cognitive Skills for Decision Making (interRAI Manual Section C.1)

#### *Coding:*

- 0 Independent — The person’s decisions in organizing daily routines and making decisions were consistent, reasonable, and safe (reflecting lifestyle, culture, values).
- 1 Modified independence — The person made reasonable and safe decisions in familiar situations but experienced some difficulty in decision making when faced with new tasks or situations only.
- 2 Minimally impaired — In specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
- 3 Moderately impaired — The person’s decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
- 4 Severely impaired — The person never (or rarely) made decisions.
- 5 No discernible consciousness, coma — The person is nonresponsive.

#### *Example:*

**Mr. Grey** shares that his daughter puts his clothes out at night so that he doesn't need to. He says that he appreciates this because it is too difficult to select things. He shares that he does not care what food he eats or television programs that are on in the living room. He says it is all just too much and that he cannot make decisions for himself anymore. In response to the assessor asking him what he likes to do, Mr. Grey says to ask his daughter. When the daughter was asked about her involvement in decision making, she indicated that Mister Grey consistently selected clothing that was inappropriate for the weather and that if it were up to him, he would eat a bowl of cereal and some carrot cake for every meal. She also shared that he needed to be reminded about brushing his teeth, washing his hands and eating on a schedule.

Based on the feedback from Mr. Grey and his daughter, Mr. Grey would be coded as a “3” for moderately impaired. He could make decisions, but they would likely be poor or unsafe. Additionally, he required reminders for basic activities.

**Mr. Harris** shared that he was experiencing primarily a sense of physical decline. He had difficulty dressing himself and getting ready for the day. He did select his own clothing, what he would like to eat and where he would like to go during the day. He did share that he became very uncomfortable if he was asked to do something new. His son had tried to help him perform some activities using his computer. He became agitated and knocked the computer off the table. The assessor spoke with his son. The son indicated that as long as Mr. Harris followed a familiar schedule, visited familiar places and did not experience any variation that he was fine.

However, Mr. Harris nearly signed himself out of a rehab facility because it was new and he had difficulty adjusting.

Based on feedback from Mr. Harris and his son, Mr. Harris could be coded as a “1” for modified independence. It would depend on the assessor’s professional judgment about the severity of Mr. Harris’s ability to deal with new situations.

### Memory/Recall Ability (interRAI Section C.3)

#### *Coding*

- 0 Yes, memory OK
- 1 Memory problem

#### *Examples:*

The assessor asked Mr. Grey to remember three unrelated items (book, watch, and table) for a few minutes. After the assessor stated all three items, she asked Mr. Grey to repeat the three items to verify that Mr. Grey heard and understood what she said. Then the assessor talked about other things related to the assessment. After 5 minutes of talking about food and meals, she asked Mr. Grey to repeat the name of each item. He could not recall them.

Mr. Grey would be coded as 1 for memory problem in short term memory.

Next, the assessor asked Mr. Grey to describe the steps he took to get ready in the morning. Mr. Grey could not remember key parts of the steps, such as putting on a shirt, brushing his teeth and combing his hair.

Mr. Grey would be coded as 1 for memory problem in procedural memory.

The assessor noticed pictures around Mister Grey's home. She asked him who was in the photos. Mr. Grey was able to accurately point out and name every person in the photos. His caregiver walked into the room during this conversation. Mr. Grey was able to introduce her to the assessor.

Mr. Grey would be coded as 0 memory, OK for situational memory.

### Periodic Disordered Thinking or Awareness (interRAI Manual Section C.4)

#### *Coding:*

- 0 Behavior not present
- 1 Behavior present, consistent with usual functioning
- 2 Behavior present appears different from usual functioning — For example, new onset or worsening; different from a few weeks ago.

*Example:*

Mr. Grey was observed to have episodes of rambling speech on 2 of the last 3 days. This behavior has been present for some time, and its frequency has not changed. It occurs during the day and evening; Mr. Grey generally sleeps through the night. He is able to pay attention to conversations, participate in conversations and understand conversations with his caregiver.

Code: Easily distracted = "0" = "Behavior not present".

Code: Episodes of disorganized speech = "1" = "Behavior present, consistent with usual functioning".

Code: Mental function varies over the course of the day = "0" = "Behavior not present".

**Acute Change in Mental Status from Person's Usual Functioning (interRAI Manual Section C.5)**

*Example:*

The assessor asked Mr. Grey if things had changed in his life recently. He indicated that things have been the same for a while. The assessor asked Mr. Grey's daughter and caregiver if his current level of functioning was typical or if there had been a recent decline in functioning. Specifically, was Mr. Grey more lethargic or restless more difficult to arouse? Both the caregiver and his daughter indicated that Mister Grey had been as he is now for at least a year.

Mr. Grey would be coded as 0 behavior not present.

## Section C Mood and Behavior

This sector indicator is observed regardless of the cause. Assessors will code in several categories including wandering, verbal abuse, physical abuse, socially inappropriate or disruptive behavior, inappropriate public sexual behavior or public disrobing, and resists care. Each item is coded separately. The observation period includes the assessment reference date and the two days prior. This is referred to as “the last three days” in conversation with people. The instructions and guidance for assessing people are in Section E.4 of the interRAI Manual.

### *Coding*

- 0 not present
- 1 present but not exhibited in the last three days
- 2 exhibited in one to three of the last three days
- 3 exhibited daily in the last three days

### *Examples:*

Mr. White has dementia and experiences severe impairment in making daily decisions. He wanders all around the apartment throughout the day. He is extremely hard of hearing without his hearing aid, which he wears daily. He is easily frightened by others and cannot stay still when anyone visits. Numerous attempts to redirect his wandering more than a week ago resulted in a physical response; he hit and pushed family but said nothing. Over time, family members have found him to be most content while he is wandering within the structured setting of the apartment.

Code: C1a (Wandering) = “3” = “Exhibited daily in last 3 days”.

Code: C1b (Verbal abuse) = “0” = “Not present”.

Code: C1c (Physical abuse) = “1” = “Present but not exhibited in last 3 days”.

Code: C1d (Socially inappropriate or disruptive behavior) = “0” = “Not present”.

Code: C2e (Inappropriate public sexual behavior or disrobing) = “0” = “Not present”.

Code: C1f (Resists care) = “2” = “Exhibited in one to three of the last three days”.

Mr. Grey Does not like having to rely on people. He is frequently verbally abusive to both his children and his caregiver. He screamed at them during the assessment visit using foul and inappropriate language. When the assessor attempted to have a private discussion with his caregiver, Mr. Grey interrupted and disrupted their attempts to communicate. The assessors asked his children if this was typical behavior. The children indicated that if Mr. Grey was not the center of attention in any social context, he would become loud, disruptive and verbally abusive. They also added that, though Mr. Grey had agreed to everything on the care plan, he has had a history of refusing to take his medications and refusing assistance to toilet himself.

This has resulted in near falls and messy cleanup activities. He has physically pushed and slapped his children and care workers. He refused care and medications the day before the assessor came to visit.

Code: C1a (Wandering) = "0" = "Not present"

Code: C1b (Verbal abuse) = "3" = "Exhibited in the last three days".

Code: C1c (Physical abuse) = "2" = "Exhibited in one to three of the last three days".

Code: C1d (Socially inappropriate or disruptive behavior) = "3" = "Exhibited in the last three days".

Code: C2e (Inappropriate public sexual behavior or disrobing) = "0" = "Not present".

Code: C1f (Resists care) = "1" = "Present but not exhibited in last 3 days".

## Section D Functional Status

Functional status includes 3 subsections: activities of daily living, locomotion and managing medications. Functional Status is documented in Section G of the interRAI Manual.

### Activities of Daily Living (interRAI Manual Section G.5) Process/Overview

- Observe how the person is performing each task.
- Talk with the person to ascertain what he or she does for him- or herself in each ADL, as well as the type and level of assistance provided by others.
- If possible, talk with immediate caregivers or family members.
- Get information pertaining to all aspects of the ADL definitions. For example, when discussing “Personal hygiene” (Item G5c), inquire how the person manages washing in the morning, combing hair, brushing teeth, and shaving. A person can be independent in one aspect of personal hygiene yet requires extensive assistance in another aspect.
- Finally, weigh all responses to come up with a consistent picture of the person’s ADL performance for each task.

### Coding Activities of Daily Living

0. Independent. No physical assistance, setup, or supervision in any episode.

1. Independent, setup help only. Articles, tools, or devices were provided or placed within reach, but there was no physical assistance or supervision in any episode. This could include a caregiver laying out all of the items necessary to change an ostomy appliance. It could be a caregiver setting up pots, pans, and cutting boards to assist in meal preparation.

2. Supervision. The person required oversight or cueing to complete the task. This could be more prevalent when the person is experiencing cognitive decline. The caregiver may set out the person’s clothes and remind them to change from pajamas to appropriate day wear. The caregiver may stay in the bedroom to ensure that the individual puts on their clothing accurately and completely.

3. Limited assistance. Limited assistance includes guided maneuvering of limbs and physical guidance without taking weight. This could include guiding a hand or arm into a sleeve without taking the weight of the arm. The person lifted their arms on their own.

4. Extensive assistance. This is weight-bearing support including lifting limbs by one helper with the person still performing 50% or more of the task. Only one helper is needed, and that helper provides weight-bearing support, including lifting limbs. This would include supporting an individual who could not lift their arm into a sleeve. If the caregiver had to lift the arm up into the sleeve, taking the weight of the arm, that would be coded as extensive assistance.

5. Maximal assistance. This is weight-bearing support including lifting limbs by two or more helpers. It can include weight-bearing support for more than 50% of the task. If two caregivers

are required to maneuver an individual into a shower chair, that would be maximal assistance. If the person requires a lift system to get out of bed, that is maximal assistance.

6. Total dependence. In a situation where the entire task is performed by others in all episodes. That is full performance by others during all episodes.

8. Activity did not occur during the entire period. Non-occurrence is occasionally confused with a person's total dependence in an ADL activity. Non-occurrence is non-occurrence regardless of the person's ability to self-perform. If the person did not bathe in the three-day observation period, the coding is "8." The comments section is used to provide reasons and context.

## Coding Process and Rules

The process and the coding rules are:

To describe functioning, the assessor should first get a sense of the number of times, or “episodes,” of each ADL activity over the course of the 3-day look back which includes the date of assessment. The interRAI manual refers to this as the 3-day observation period. In conversation, the phrases “last three days” or “three-day look back” may make more sense in general conversations.

If all episodes in the last 3 days were performed at the same support level, score the ADL at that level. Also note that this rule applies when there was only one performance episode during the 3-day period. For example, if over the course of the 3 days the person moved once between locations on the same floor but was bed-bound for the remainder of the time, then the score for Item G5g (“Locomotion”) should be based on the single episode when the person moved.

Note that to receive a score of “0” (“Independent”), “6” (“Total dependence”), or “8” (“Activity did not occur”), all performance episodes must be at the same level.

If any episodes would be coded as “6” (“Total dependence”) and other episodes would be coded as less dependent, code the item as “5” (“Maximal assistance”).

Otherwise, focus on the three most dependent episodes (or the two most dependent episodes if the ADL was only performed twice). If the most dependent of these episodes would be scored “1” for “Independent, setup help only”, score the item “1”. If the most dependent of these episodes would receive a higher score, however, code the item to match the least dependent of those episodes in the range between — “2”, “3”, “4”, and “5”.

When an ADL occurs 3 or more times, pick the 3 most dependent episodes (If only 2 episodes occurred, use both) and Code the *least dependent* (lowest score) among those selected episodes.

### *Example 1: Mostly independent with one worse episode*

Toilet Transfer

- Day 1: 1-Independent-set-up only, 1-Independent-set-up only
- Day 2: 3-Limited Assistance
- Day 3: 1-Independent-set-up only

Pick 3 most dependent- **1,1,3**, 1

- Most dependent = 3
- Least dependent in that set = 1
- Final Code = 1

*Example 2: Consistent need for help*

- Day 1: 2-Supervision, 3-Limited Assistance
- Day 2: 2-Supervision
- Day 3: 3-Limited Assistance

Pick 3 most dependent – **2,3,2**, 3

- Most dependent = 3
- Least dependent = 2

Final Code = 2

*Example 3: High variability*

- Day 1: 5-Maximal Assistance, 3-Limited Assistance
- Day 2: 2-Supervision
- Day 3: 1-Independent-set-up only

Pick 3 most dependent - **5, 3, 2**

- Most dependent = 5
- Least dependent = 2

Final Code = 2

**Example 4: Only two episodes-** Use the worst episodes to define the range, then code the lowest level within that range (unless all are 1).

Episodes: 4, 3

- Day 1: 4-Extensive Assistance
- Day 2: 3-Limited Assistance
- Day 3: 8-Did not Occur

Use both -4, 3

- Most dependent = 4
- Least dependent = 3

Final Code = 3

When **all** episodes over the course of the 3-day observation period (lookback) were performed at the same support level, score the ADL at that level.

3-day lookback episodes:

- Day 1: 3 (Limited assistance)
- Day 2: 3 (Limited assistance)
- Day 3: 3 (Limited assistance)

All episodes are the same.

Final Code = 3 (Limited assistance)

When there is **only one performance episode** during the 3-day lookback, code the ADL based on that single episode.

ADL: Bathing

(Only occurred once in 3 days)

Day 1: 8-Activity did not occur

Day 2: 4 (Maximal assistance)

Day 3: 8-Activity did not occur

Only one actual performance episode.

Final Code = 4 (Maximal assistance)

With only one episode, that episode = the score.

You can only code 0, 6, or 8 if every single episode is exactly the same.

*Example: ADL: Eating*

- Day 1: 0-Independent
- Day 2: 0- Independent
- Day 3: 0-Independent

All independent  
Final Code = 0

Use 0, 6, or 8 only when performance is completely uniform across all episodes in the 3-day lookback.

When the person is totally dependent (6) in some episodes, but less dependent in others, you cannot code 6, you must code 5 (Maximal assistance). This rule takes precedence over the “3 most dependent episodes” rule. Once a coded “6” is part of the lookback and there are episodes of less than a 6, the code is automatically a 5. This ensures that, even if the other days have a very low code, that the episode of full dependence is taken into consideration.

*Example: Bath Transfer*

- Day 1: 6-Dependent
- Day 2: 6-Dependent
- Day 3: 5-Maximal Assistance

Final Code- 5 Maximal Assistance

*Example: Bath Transfer*

- Day 1: 6-Dependent
- Day 2: 4-Extensive Assistance
- Day 3: 3-Limited Assistance

Final Code- 5 Maximal Assistance

### *Bathing, Bath Transfer and Personal Hygiene*

In conversation, **Mrs. Smith** indicates that she kept somewhat clean every day in the three-day observation period. The service coordinator asked her about her bathing routine. Mrs. Smith noted that she is unsteady on her feet. She also has range of motion issues due to shoulder instability and lack of mobility. Her shower is in a bathtub and requires a significant step to access. She cannot take the step and stand long enough to take a shower. She required weight-bearing support in order to bathe at the sink. After a minute, she was too unsteady to stand alone. She would prefer to fully clean her body and hair in the shower, but she is too unsteady to get in the shower. She cannot stand for the time it would take at the sink or move her arms and coordinate the action to reach all body parts. She needs help and supervision to comb her hair and groom herself. If she drops items, she cannot retrieve them from the floor.

- The bathing category would be coded as “4,” for extensive assistance.
- The bathing transfer would be coded as “8” for activity did not occur.
- Mrs. Smith’s personal hygiene coding would be “2” for supervision.

\*The assessor must observe and use professional judgement to determine how effective the sink bath process is in order to code accurately.

**Mr. Jones** has a spinal injury. He is paralyzed from the chest down. He noted that his caregiver assists him with bathing on a fixed schedule.

Mr. Jones does have daily assistance to complete personal hygiene activities. His caregiver transfers him to his chair; pushes him to the bathroom; and lays out his comb, toothbrush, toothpaste, and mouthwash so that Mr. Jones can reach them.

Mr. Jones has use of his upper body and can comb his own hair, brush his teeth, and use mouthwash on his own. His caregiver stays close by in case he drops items or spills things. Mr. Jones cannot yet retrieve things from the floor. His caregiver washed his hair at the sink during the look back period, and Mr. Jones completed other grooming tasks.

#### Bathing

Day 1- 6 Total dependence

Day 2- 8 Activity did not occur during the entire period

Day 3- 8 Activity did not occur during the entire period

Mr. Jones is on a fixed bathing schedule. He bathed once during the look back period. The caregiver performed the entire bathing activity with no assistance from Mr. Jones.

- The coding for bathing would be 6 for total dependence
- The coding for bath transfer would be “6” for total dependence
- The coding for personal hygiene would be “2” for supervision

### *Walking and Locomotion*

**Mrs. Smith’s** concerns with getting in and out of the shower are reasonable. The assessor observes that, in order to walk across a room safely, Mrs. Smith holds onto furniture the whole way. She does not need to be supervised. The coding for walking would be “0,” independent.

Mrs. Smith does not need set-up or assistance. For locomotion, she would also be scored as a “0.” She uses the wall to provide balance when she moves between rooms. If an Assessor believes that Mrs. Smith’s reliance on furniture and walls is functionally important and worth documenting, they can note it in the comments.

**Mr. Jones** uses a wheelchair and did not walk.

His walking score would be a “8” for Activity Did Not Occur.

Locomotion assesses Mr. Jones’ performance in the wheelchair.

If he may be coded “3” for limited assistance, if he needs help maneuvering.

If he can navigate without help throughout his living space, he could be coded as a “1”

### *Toilet Use and Transfer Toilet*

**Mr. Johnson** discloses that he is able to get on and off of the toilet if he uses his cane or walker. The coding for transfer toilet would be “0” for independent. He is also able to clean up afterward. The coding for toilet use would be “0” for independence.

**Mrs. Smith** had an indwelling catheter and an ostomy appliance (bag) place during the entire three-day assessment period. She never used the commode. The coding for transfer toilet would be “Activity Did Not Occur. Mrs. Smith managed all aspects of changing, cleaning and using the catheter and ostomy bag. The coding for toilet use would be “0” for independence.

**Mrs. Violet** has a new condition. She can no longer walk due to a degenerative disease. In the last three days, she has been toileted only with the help of her caregiver to transfer her out of her chair and onto the toilet. She is completely dependent on her caregiver for toileting. The

code would be "6" for total dependence. Her caregiver also arranged her clothes afterward. She did not participate in any of the tasks for toileting. The coding for toilet use would be "6" for total dependence.

Please note that if Mrs. Violet were able to participate in any of the activities related to toilet use, her coding would be a 5 for maximal assistance.

## Managing Medications (interRAI Manual Section C.2.b)

**Mr. Harris** takes medications daily. Some require an empty stomach, and some require food with the pill. Mr. Harris is aware of this and has developed habits to make sure that he takes the medicines accordingly.

He has enough grip strength to open his medications. He requested the non-childproof lids from his local pharmacy. He has read and keeps in a filing cabinet all of the information that the pharmacy provided about each drug. He requested and received these written materials in large print.

Mr. Harris is fully independent. His score in capacity would be “0” for independent.

**Mrs. Green** relies on a caregiver and her daughter to purchase her medications and set them up in a pill pack that has the times of day noted on the pack. This way, Mrs. Green can see that she took her morning, afternoon, evening, and night-time pills.

Mrs. Green, due to her arthritis and low vision, cannot read the prescription instructions and cannot open the bottles for herself in order to set up her morning, afternoon, evening, and medications. Therefore, she would be scored as a “1” for setup help only. If she is able to describe her medication schedule and the purpose of each medication, the code would be “1”.

If it came to light that Mrs. Green relies on the medication box to make sure that she has taken the pills at the right time of day because she doubts she could remember and expressed uncertainty regarding the effect of the medicines on her body and mind, her coding should shift to “2” for supervision.

If Mrs. Green did not have her caregiver or daughter to supervise her, she would not have the capacity to manage her medications.

Remember, if you are in a situation in which you are unsure about a coding score, use the comments field to describe why you selected the score. In the case of Mrs. Green, if you speculate that she can safely manage her medications with proper setup and believe that the daughter is being overly concerned, include those notes to justify your score of “1” for capacity.

Likewise, if you are not confident that Mrs. Green can remember to take her pills at the right time and understand side effects and how the medications are affecting her, use the comments field to justify a coding of “2” for supervision.

**Mr. Yee** takes some of his medications daily. He manages his daily medications independently. He understands the instructions and can open the bottles. On a monthly basis, Mr. Yee receives an infusion intravenously and must take an injection at the end of the 24-hour infusion.

He is totally dependent on a registered nurse to administer the 24-hour infusion through an intravenous delivery system. He can observe himself and monitor side effects of the infusion.

On some elements he is fully independent. On others he is totally dependent. And, in terms of the injection, he may need setup or supervision. In this case, remember to use comments to justify the selection you make.

The coding in this situation is limited to his daily medications. He is totally independent and could be coded as “0” for independent.

The monthly infusion and subsequent shots are treated like a medical appointment in terms of function eligibility.

**Mr. Johnson** has severe arthritis in his hands. Even with the non-child-proofed bottles, he cannot independently open pill bottles and dispense the right number of pills. The caregiver sets up his pills at each meal so that Mr. Johnson can put them in his mouth and swallow them. In this case, Mr. Johnson’s medication management would be coded as a “1” for setup help only.

## Section E Contenance

The instructions for assessing and coding are in the interRAI Manual Section H.

### Coding for Bladder Contenance

- 0 Continent — Stays dry with or without any urinary management device and has no accidental spillage.
- 1 Infrequently incontinent — Not incontinent over last 3 days but does have a recent history of incontinent episodes.
- 2 Occasionally incontinent — Less than daily episodes of bladder incontinence (incontinent on 1–2 of the last 3 days).
- 3 Frequently incontinent — Incontinent daily, but some control present (the person is not incontinent during each episode of urination). Example: During the day, the person remains dry and is continent of urine. At night, the person wets pants or bedding.
- 4 Incontinent — No control of bladder; multiple daily episodes all or almost all of the time.
- 8 Did not occur — No urine output from bladder in last 3 days.

#### *Bladder Contenance Examples*

**Mr. Quick** was taken to the toilet after every meal, before bed, and once during the night. He was never found wet.

Code: = “0” for “Continent”.

**Mr. Rodriguez** had an indwelling catheter in place during the entire 3-day assessment period. He was never found wet.

Code: H1 = “0” = “Continent”, in this case with a urinary management device — the device is noted under a separate item in the interRAI HC Assessment.

**Mrs. Teague**, although generally continent of urine, every once in a while, (4 and 6 days ago over the last week), she did not make it to the bathroom to urinate in time after taking her daily diuretic pill.

Code: “1” = “Infrequently incontinent”.

**Mrs. Apple** has an occasional episode of urinary incontinence (generally less than daily), particularly late in the day when she is tired. In the last 2 days, she was not incontinent at all. She was incontinent 3 days ago, however.

Code: “2” = “Occasionally incontinent”.

**Mrs. Underwood** has end-stage Alzheimer’s disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress and is turned and repositioned hourly for comfort. In the last 3 days, she was not toileted and was incontinent for all episodes.

Code: “4” = “Incontinent”.

### Coding for Bowel Continence

- 0 Continent — Stays continent, with or without the use of an ostomy device.
- 1 Infrequently incontinent — Not incontinent over last 3 days but does have incontinent episodes.
- 2 Occasionally incontinent — Incontinent episodes less than daily.
- 3 Frequently incontinent — Incontinent daily, but person has some control.
- 4 Incontinent — No control present.
- 8 Did not occur — No bowel movement in the last 3 days.

#### *Examples of Bowel Continence*

Mr. Harris shares in conversation, that when he eats a large meal (especially at holidays and celebrations) that he has had “accidents” with bowel control. This happens about 4 times per year. He would be coded as infrequently incontinent.

Mrs. Green shares that she has started using Depends because she has had accidents with both bladder and bowel continence. The accidents have been more frequent in the last 6 months, and she needs to change her Depends during the day, sometimes twice per day. It is not every time, but it is increasing. She would be coded as a 3 for bladder and bowel continence.

Mr. Yee has no control of his bowels or bladder. He is scored as a 4 for incontinent in both categories.

## Functional Eligibility Determination (FED) Scoring

The scoring matrix for functional eligibility includes items A through H. Each item can include more than one coded response. The items consider full deficits and partial deficits in scoring.

To be determined as Nursing Facility Clinically Eligible (NFCE), an individual must have three partial deficits or any full deficits.

Please refer to the June 8, 2008 *Updates to the Functional Eligibility Determination Process Bulletin* for more information on scoring for eligibility determinations.

### FED Scoring Matrix

|       | A   | B  | C   | D   | E   | F   | G   | H   |
|-------|---|--|---|---|---|---|---|---|
| Score | <ul style="list-style-type: none"> <li>• B.1. Cognitive Skills for Daily Decision Making</li> </ul> | <ul style="list-style-type: none"> <li>• B.2.a Short-Term Memory</li> <li>• B.2.b. Procedural Memory</li> <li>• B.2.c. Situational Memory</li> </ul> | <ul style="list-style-type: none"> <li>• B.3.a. Easily Distracted</li> <li>• B.3.b. Disorganized Speech</li> <li>• B.3.c. Mental Function Varies</li> </ul> | <ul style="list-style-type: none"> <li>• C.1.a. Wandering</li> <li>• C.1.b. Verbal Abuse</li> <li>• C.1.c. Physical Abuse</li> <li>• C.1.d. Socially Inappropriate or Disruptive</li> </ul> | <ul style="list-style-type: none"> <li>• D.1.a. Bathing**</li> <li>• D.1.b. Bath Transfer**</li> <li>• D.1.c. Personal Hygiene</li> <li>• D.1.d. Dressing Upper Body</li> <li>• D.1.e. Dressing Lower Body</li> <li>• D.1.f. Walking</li> <li>• D.1.g. Locomotion</li> <li>• D.1.h. Transfer Toilet</li> <li>• D.1.i. Toilet use</li> <li>• D.1.j. Eating.</li> </ul> | <ul style="list-style-type: none"> <li>• D.2.a. Primary Mode of Locomotion</li> </ul> | <ul style="list-style-type: none"> <li>• D.3. Managing Medications</li> </ul> | <ul style="list-style-type: none"> <li>• E.3. Bowel Continence</li> </ul> |
| 0     |   |  |   |   |   |   |   |   |
| 1     |   | A score of 1 on one or more bullets = PARTIAL DEFICIT  | A score of 1 or 2 on one or more bullets = PARTIAL DEFICIT  |   |   |   |   |   |
| 2     | A score of 2 to 4 = PARTIAL DEFICIT   |  |   | A score of 2 or 3 on one or more bullets = PARTIAL DEFICIT  |   | A score of 2 = PARTIAL DEFICIT  |   |   |
| 3     | A score of 5 = FULL DEFICIT   |  |   |   | A score of 3 to 6 on any two bullets = PARTIAL DEFICIT  | A score of 3 = FULL DEFICIT   |   |   |
| 4     |   |  |   |   | A score of 3 to 6 on three or more bullets = FULL DEFICIT   |   |   | A score of 4 or 5 = FULL DEFICIT  |
| 5     |   |  |   |   | **Any deficit in both Bathing and Bath Transfer may be counted as 1 bullet.   |   | A score of 5 or 6 = PARTIAL DEFICIT   |   |
| 6     |   |  |   |   |   |   |   |   |

= Little or no deficit  
 = Score not available for the attribute(s)

ANY THREE PARTIAL DEFICITS = NFCE

ANY FULL DEFICIT = NFCE

## FED Scoring Examples

Mr. Yee is coded as a 4 for bowel continence. That is a full deficit and he would be NFCE.

Mrs. Green has partial deficits in Bathing and Dressing. She has partial deficits in bowel continence and in distraction. She was distracted and had some short-term memory issues. She also has partial deficits in walking and locomotion. The three partial deficits result in an NFCE designation.

Mr. Harris clearly needs assistance with housework. Because he can get around with the use of his cane, he does not have enough partial deficits to be NCFE at this point. His mind is clear. He has no mental or behavioral deficits. He must be careful in the shower, but his son installed grab bars for safety. He has a raised toilet seat, so he can still transfer. At this point, he would be NFI.

Mr. Grey has partial deficits in multiple categories in items A through E on the scoring matrix. Based on the three partial deficits, Mr. Grey would be determined to be NFCE.

## Terms and Acronyms

ADL – Activity of Daily Living

AWP – Aging Well PA

CHC – Community HealthChoices

FED – Functional Eligibility Determination

HC – Home Care

HCBS – Home and Community-Based Services

IADL – Instrumental Activity of Daily Living

ID – Identification

IEB – Independent Enrollment Broker

MCO – Managed Care Organization

NFCE – Nursing Facility Clinically Eligible

NFI – Nursing Facility Ineligible

OLTL – Office of Long-Term Living

PIA – Pennsylvania Individualized Assessment

PCSP – Person-Centered Service Plan

SC – Service Coordinator