

APPENDIX B

TELEPHONIC RISK ASSESSMENT INSTRUMENT (FOR USE AS BOTH INITIAL AND FINAL ASSESSMENT)

Referral Number

Participant Name: _____

Address: _____

Phone Number: _____

Independent Living
and
Mobility Program
Phone Screening
Assessment

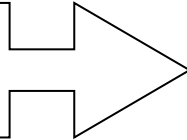
Assessor – Print your name with credentials and the date that the interview was completed.

Name and credentials: _____

Date of interview: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-0308 . The time required to complete this information collection is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Enter the time the interview begins (i.e. 2:53 PM).



Exact time:
: am/pm

● **Introduction**

INITIAL CONTACT- Talking to insured

Hi, my name is _____ and I am calling on behalf of *(Name of Insurance Company)*, your long-term care insurance company. A few weeks ago, you agreed to participate in a national Program about Independent Living and Mobility that your LTC insurance company is participating in. First, we want to thank you for your willingness to contribute to helping us understand such an important issue. As part of the Program, we need to ask you some questions related to your general health history. It will take about 20 minutes. Do you have time to do that now or would you like to schedule a time that is more convenient for you?

INITIAL CONTACT - Talking to proxy

Hi, my name is _____ and I am calling on behalf of *(Name of Insurance Company)*, *(the insured's name)*'s long-term care insurance company. A few weeks ago, you agreed to participate in a national Program about Independent Living and Mobility that their LTC insurance company is participating in. First, we want to thank you for your willingness to contribute to helping us understand such an important issue. As part of the Program, we need to ask you some questions related to *(name of insured)*'s general health history. It will take about 20 minutes. Do you have time to do that now or would you like to schedule a time that is more convenient for you?

FINAL CONTACT - Talking to insured

Hi, my name is _____ and I am calling on behalf of *(Name of Insurance Company)*, your long-term care insurance company. You have been participating in a national Program about Independent Living and Mobility for the past 24 months. As the last telephone contact, we need to ask you the questions that we asked you at the very beginning of the Program. It will take about 20 minutes. Do you have time to do that now or would you like to schedule a time that is more convenient for you?

FINAL CONTACT - Talking to proxy

Hi, my name is _____ and I am calling on behalf of *(Name of Insurance Company)*, *(the insured's name)*'s long-term care insurance company. *(the insured's name)* has been participating in a national Program about Independent Living and Mobility for the past 24 months. As the last telephone contact, we need to ask you the questions that we asked at the very beginning of the Program. It will take about 20 minutes. Do you have time to do that now or would you like to schedule a time that is more convenient?

● **General Questions**

1. Are you having any difficulty understanding me? (If "Yes," explain how you compensated below)..... Yes No

Compensation: _____

2. With whom do you live? Alone Spouse Child(ren) Grandchild(ren) Parent

Sibling Other (name/relationship: _____)

3. Do you live in a private residence (Free standing home or apartment/condominium)? No

Yes

If Yes, Is this part of an: Assisted Living Facility, Retirement Community or Elderly Housing?.....

No.....

Yes

If Yes, indicate which: Assisted Living Facility Retirement Community Elderly Housing

If No, Do you live in: Assisted Living Facility Retirement Community Nursing Home

Other, type: _____

4. At the present time would you say your health is: Excellent Good Fair Poor

● **Healthcare Use**

5. Do you have a primary care doctor or other physician you see regularly or when you have a medical problem?.....No
Yes
6. How often do you usually see a doctor? Monthly ~3 Mo ~6 Mo
Yearly ≤ Yearly Rarely
7. In the past 2 years, have you had any surgery?.....No
Yes
If Yes, indicate number of times: _____
8. In the past 2 years, have you had any emergency room visits?.....No
Yes
If Yes, indicate number of times: _____
9. In the past 2 years, have you had any hospital admissions?.....No
Yes
If Yes, indicate number of times: _____
10. Do you receive personal care or assistance from any paid or unpaid caregivers?.....No
Yes
If Yes, Identify: Paid Caregiver(s) Unpaid Caregiver(s)
Both Paid and Unpaid Caregiver(s)
Approximately how much money do you spend per month on these paid caregivers?
none less than \$100 \$100-\$250 \$251-\$500
\$501-\$1000 \$1001 or more

● **Medical Conditions and Symptoms**

11. In the past week or so, have you felt any...
- a. Lower body muscle weakness or generalized fatigue?.....N Ye
o s
- b. Pain in your back that affects your mobility or daily activities?.....N Ye
o s
- c. Loss of balance or unsteadiness when you walk or get up from a chair or bed?.....N Ye
o s
- d. Dizziness or vertigo when you walk or get up from a chair or bed?.....N Ye
o s
12. Has a doctor ever told you that you have...
- e. Arthritis, Bone or Joint problems affecting your mobility, legs, hips, knees, ankles or feet?.....N Ye
o s
13. Do you have...
- f. Paralysis of a leg or foot?.....N Ye

- g. An amputation of a leg, foot or toe?.....
 N Yes
- h. Impaired vision that cannot be corrected or are you blind?.....
 N Yes

● **Medications**

14. Are you currently taking any prescription medications?..... No
 Yes

If Yes, how many different medications do you take per day?
 1-3 4-6 7-10
 More than 10

15. Are you currently taking any non-prescription or over the counter medications?..... No
 Yes

If Yes, how many different medications do you take per day?
 1-3 4-6 7-10
 More than 10

16. Do you ever forget to take a medication or decide not to take one?..... No
 Yes

If Yes, About how often does this happen? 1-3 times/wk 4-6 times/wk More than 6 times/wk
 Why does this happen? Forgets Too expensive Other: _____

17. Do you take medication for any of the following conditions?

	N	Ye		N	Ye
	o	s		o	s
Anxiety.....	<input type="checkbox"/>	<input type="checkbox"/>	Stress.....	<input type="checkbox"/>	<input type="checkbox"/>
Depression.....	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss or Memory Impairment.....	<input type="checkbox"/>	<input type="checkbox"/>

18. Have you ever been treated for Depression?..... No
 Yes

If Yes, Are you currently being treated for depression? No
 Yes

● **Falls History and Risks**

19. How many times in the past 6 months have you had an episode of fainting, falling or dropping to the ground or lost your balance, slipped or tripped over something that resulted in falling or dropping to the ground?..... _____ Times

a) If one (1) or more times, Did you get hurt? No
 Yes

b) What has been your most serious injury or problem due to any fall? (check all that apply)

- Never Injured Bruises Cuts Discomfort Fracture of leg Fracture of wrist or arm
 Fracture of back/vertebrae Head injury Other (specify) _____

c) How long were you on the ground before you could get up?

20. Do you ever limit your activities, for example, what you do or where you go because you are afraid of falling?..... No
 Yes

21. Some things help to prevent falls. Do you currently do any of these?

a) Exercise program..... No
 Yes

- If "Yes" what type? Yoga Stretching Tai Chi Walking
 Weights/Strengthening exercises
 Swimming Other (Specify)

b) Regularly see your doctor..... No
 Yes

c) Participate in a community based fall prevention program... No
 Yes

----- previously we asked have you EVER participated in falls prevent. Program do we want to ask this?

● **Modified Geriatric Depression Scale (GDS IV)**

1. Please choose the best answer for how you have felt over the past week.

Assessor, yes and no check boxes reverse depending on whether the question is posed as positive or negative.

Question	Not Depresse	Depressed
-----------------	-------------------------	------------------

- d**
- 1 Are you basically satisfied with your life?.....Yes.....No.....
- 2 Have you dropped many of your activities and interests?.....No Yes
- 3 Are you afraid that something bad is going to happen to you?.....No Yes
- 4 Do you feel happy most of the time?.....Yes.....No.....

Total number of Depressed answers: _____

● **TICS**

2. Next, I am going to ask you some questions to test your memory. Some of these are likely to be easy for you, but some may be difficult. Please bear with me and try to answer all the questions as best you can. If you can't answer a question, don't worry, just try your best. If you have a television or radio on, please turn it off so that you are not distracted for this part of the interview. Are you ready?No
Yes

If No, why not? Refused to complete Other, explain _____

Question	Answer	Correct	Incorrect
Please tell me your full name	First:		
	Last:		
What is today's date?	Month:		
	Day:		
	Year:		
	Day of week:		
	Season:		
Where are you right now?	Number:		
	Street:		
	City:		
	State:		
	Zip Code:		
Please count backwards from 20 to 1	1 st try:		
If error: Please count backwards from 20 to 1	2 nd try:		

I am going to read to you a list of 10 words. Please listen carefully and try to memorize them. When I am done, tell me as many of the words as you can in any order. Ready? OK, the words are... Assessor – say each word slowly and use clear enunciation. Pause for 1 second after each word is said..

Cabin	Check if recalled:			
Pipe	Check if recalled:			
Elephant	Check if recalled:			
Chest	Check if recalled:			
Silk	Check if recalled:			
Theater	Check if recalled:			
Watch	Check if recalled:			
Whip	Check if recalled:			
Pillow	Check if recalled:			
Giant	Check if recalled:			
I would like you to take the number 100 and subtract 7	Answer:			
Now keep subtracting 7 from the answer				

Until I tell you to stop	Answer:			
	Answer:			
	Answer:			
	Answer:			
What do people usually use to cut paper?	Answer:			
How many things are in a dozen?	Answer:			
What do you call the prickly green plant that lives in the desert?	Answer:			
What animal does wool come from?	Answer:			
Please repeat this after me "No ifs, ands or buts"	Answer:			
Now please repeat this after me "Methodist Episcopal"	Answer:			
With the tip of your finger, tap 5 times into the part of	Taps are heard:			
the phone you speak into. Total number of taps = 5:				
I am going to say a word and I want you to give me its opposite. For Example, if I said "hot" you would say "cold"				
What is the opposite of west?	Answer:			

Total correct: _____

● Ambulation

3. Do you have difficulty walking without help from another person?..... No
Yes
4. Do you have difficulty getting in and/or out of your home?..... No
Yes
5. Do you have difficulty walking from one room to another inside your home? No..... Yes
6. Do you have difficulty walking inside your home without the use of furniture or other items to steady yourself?..... No
Yes
7. Do you have any electrical cords, furniture or clutter that cross walkways, hallways or pathways in your home?..... No
Yes
8. Do you have any slippery throw rugs (scatter rugs) in your home that are not fastened to the floor?..... No
Yes
9. Do you have difficulty getting around outside your home within walking distance including negotiating uneven surfaces?..... No
Yes

● **IADL/ADL Evaluation**

10. Do you have difficulty doing any of the following activities without help from another person?
- a) TAKING YOUR MEDICATIONS: (opening bottles, measuring correct doses, taking them at the correct time)?.....No
Yes
 - b) USING THE TELEPHONE: (answering the phone. looking up numbers and dialing)?.....No
Yes
 - c) MANAGING YOUR FINANCES: (paying bills, writing checks, balancing your checkbook)?.....No
Yes
 - d) DOING YOUR HOUSEWORK: (making beds, dusting, vacuuming, cleaning the floors, the kitchen and bathroom)?.....No
Yes
 - e) DOING YOUR LAUNDRY: (transferring clothes to/from washer/dryer, and putting clean items away)?.....No
Yes
 - f) SHOPPING FOR GROCERIES: (getting to store, obtaining, paying for, carrying home and putting away all needed items)?.....No
Yes
 - g) TRANSPORTING YOURSELF: (driving or arranging a ride, getting to/from and in/out of the vehicle by yourself)?.....No
Yes
 - h) PREPARING YOUR MEALS: (planning, preparing and serving complete, well-balanced meals)?.....No
Yes
 - i) GETTING IN AND OUT OF A BED OR CHAIR?.....No
Yes
 - i) Getting in and out of a chair without using your hands to push off?.....
No.....
Yes
 - ii) Getting up from the floor without help from another person?.....
No.....
Yes
 - j) DRESSING AND UNDESSING YOURSELF?.....No
Yes
 - k) BATHING YOURSELF?.....No
Yes
 - i) Getting in and out of your bathtub or shower?.....
No.....
Yes
 - l) FEEDING YOURSELF?.....No
Yes

m) TOILETING?..... No
Yes

i) Getting on or off of your toilet?..... No
Yes

n) MAINTAINING CONTINENCE OR CARING FOR PERSONAL HYGIENE AFTER
INCONTINENCE OCCURS?..... No
Yes

11. Do you have non-slip surfaces/mats inside and outside your
tub/shower?..... No
Yes

● **Medical Equipment**

12. In the last week or so, have you used any of the following medical equipment or devices? (if "Yes," explain below)

	N	Ye		N	Ye		N	Ye
	o	s		o	s		o	s
Wheelchair....	<input type="checkbox"/>	<input type="checkbox"/>	Electric Chair Lift..	<input type="checkbox"/>	<input type="checkbox"/>	Bedside	<input type="checkbox"/>	<input type="checkbox"/>
Walker.....	<input type="checkbox"/>	<input type="checkbox"/>	Electric Stair Lift...	<input type="checkbox"/>	<input type="checkbox"/>	Commode.....	<input type="checkbox"/>	<input type="checkbox"/>
Cane.....	<input type="checkbox"/>	<input type="checkbox"/>	Electric Cart or	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Catheter. .	<input type="checkbox"/>	<input type="checkbox"/>
			Scooter.....			Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Crutches.....	<input type="checkbox"/>	<input type="checkbox"/>	Raised Toilet Seat	<input type="checkbox"/>	<input type="checkbox"/>	Equipment.....		
			Toilet Safety	<input type="checkbox"/>	<input type="checkbox"/>	Grab Bars in Tub	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis/	<input type="checkbox"/>	<input type="checkbox"/>	Frame/grab bar....			or Shower.....		
Leg Braces....						Other:.....	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes," Why do you use the equipment? _____

Where do you use this equipment? In the home
 Outside

Approximately how much of your own money did you spend on this equipment?

I did not spend my own money less than \$50..... \$50-\$100
 \$101-\$150
 \$151-\$200 \$201-\$250 \$251-\$300 don't
know/came with house
 Other amount _____

13. Have you made any modifications to the outside or inside of your home to improve its safety?..... No
Yes

If Yes, what type of modification(s): _____
Why? _____

Approximately how much of your own money did you spend to improve your home's safety?

I did not spend my own money less than \$50..... \$50-\$100
 \$101-\$150
 \$151-\$200 \$201-\$250 \$251-\$300..... other
amount _____

● **Height and Weight**

14. What is your height? _____ ft _____ in

15. What is your weight? _____ lbs

● **Visual Acuity**

16. Do you have glasses or contact lenses? No
Yes

Do you wear them Most of the time Sometimes For
special reasons (such as driving or reading)
 Never

17. Have you had an eye exam or your vision checked by a doctor or
optometrist in the last five years? No
Yes

18. Can you see well enough (with glasses, if needed) to read the
newspaper? No
Yes

19. Can you see well enough (with glasses, if needed) to watch
television? No
Yes

20. Can you see well enough (with glasses, if needed) to read writing on
television? No
Yes

21. Can you see well enough (with glasses, if needed) to read medicine
bottles? No Yes

22. Can you see well enough (with glasses, if needed) to walk downstairs
in daylight? No
Yes

23. Can you see well enough (with glasses, if needed) to walk downstairs
in dim light? No
Yes

24. Can you see well enough (with glasses, if needed) to recognize
someone across the room? No
Yes

● **Physical Activity Scale for the Elderly (PASE)**

Now I am going to ask you some questions about your daily activities. Please let me know if in the past 7 days you have done any of these activities.

Household Activity

During the past 7 days...

- 25. Have you done any light housework, such as dusting or washing dishes?..... No Yes
- 26. Have you done any heavy housework/chores, such as vacuuming, scrubbing floors, washing windows, or carrying wood?..... No
Yes
- 27. Did you engage in any of the following activities?
Home Repairs like painting, wallpapering, electrical work etc..... No
Yes
- 28. Lawn work or yard care including snow or leaf removal, wood chopping, etc... No..... Yes
- 29. Outdoor Gardening..... No
Yes
- 30. Caring for another person such as children, dependent spouse or another adult?..... No
Yes

Work Related Activity

- 31. During the past 7 days did you work for pay or as a volunteer? (If "Yes," explain below)..... No
Yes

A. How many hours did you work in the past 7 days?	B. Which best describes the activities that are required at your work
<input type="checkbox"/> 1-8 hours	<input type="checkbox"/> Mainly sitting with slight arm movements (Office worker, watchmaker, assembly line worker, bus driver)
<input type="checkbox"/> 9-20 hours	<input type="checkbox"/> Sitting or Standing with some walking (Cashier, general office worker, light tool and machinery worker)
<input type="checkbox"/> 21-30 hours	<input type="checkbox"/> Walking with some handling of material generally weighing less than 50 lbs. (Mailman, waiter/waitress, construction or heavy tool/machinery worker)
<input type="checkbox"/> 31-40 hours	<input type="checkbox"/> Walking and heavy manual work often handling materials over 50 lbs. (Lumberjack, stone mason, farm or general laborer)

Leisure-Time Activity

Over the past 7 days, did you...

32. Take a walk outside your home or yard for any reason? (e.g.: for fun exercise, walking to work, walking the dog, etc)..... No
Yes

If Yes, How many days in the past week did you walk? _____

On Average, how many minutes per day did you spend walking? _____

33. Engage in light sport or recreational activities such as bowling, golf with a cart, shuffleboard, fishing from boat or pier or other similar activities?.....

No Yes

If Yes, How many days in the past week did you participate in these activities? _____

On Average, how many minutes per day did you spend doing these activities? _____

34. Engage in moderate sport and recreational activities such as doubles tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?..... No
Yes

If Yes, How many days in the past week did you participate in these activities? _____

On Average, how many minutes per day did you spend doing these activities? _____

35. Engage in strenuous sport and recreational activities such as jogging, swimming, cycling, singles tennis, aerobic dance, skiing (down hill or cross country) or other similar activities?..... No
Yes

If Yes, How many days in the past week did you participate in these activities? _____

On Average, how many minutes per day did you spend doing these activities? _____

36. Do any exercise specifically to increase muscle strength/endurance such as lifting weights, doing push-ups, Sit-ups etc?..... No
Yes

If Yes, How many days in the past week did you participate in these activities? _____

On Average, how many minutes per day did you spend doing these activities? _____

37. Do any exercise specifically to increase balance or flexibility (stretching) such as yoga, Tai Chi, etc?..... No
Yes

If Yes, How many days in the past week did you participate in these activities? _____

On Average, how many minutes per day did you spend doing these activities? _____

● **Demographics**

38. What is your marital status? Married Widowed Divorced..... Never Married
39. What is your date of birth? ____/____/____
40. What is your gender Male..... Female
41. What is your highest level of education? Less than high school graduate High School graduate Some college or Associate's Degree College graduate Graduate Degree
42. Which of the following describes your race? White African American or Black Asian American Indian Native Hawaiian or other Pacific Islander Other race Hispanic or Latino Refused to disclose/Uncertain

43. To get a picture of people's financial situation, we need to know your total household income from all sources, before taxes in (YEAR). This includes social security, retirement income, job earnings, dividends, public assistance, help from relatives and any other source of income you may have. Would you say that your household income was Less than \$50,000 \$50,000 or greater?

Was it:

If less than \$50,000

If greater than or equal to \$50,000

- | | |
|-------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Under \$25,000 | <input type="checkbox"/> Under \$75,000 (\$50,000-\$74,999) |
| <input type="checkbox"/> Under \$35,000 (\$25,000-\$34,999) | <input type="checkbox"/> Under \$100,000 (\$75,000-\$99,999) |
| <input type="checkbox"/> Under \$50,000 (\$35,000-\$49,999) | <input type="checkbox"/> Under \$150,000 (\$100,000-\$149,999) |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> \$150,000 and over |
| <input type="checkbox"/> Refused | <input type="checkbox"/> Don't know |
| | <input type="checkbox"/> Refused |

<i>Enter the time the interview ends (i.e. 3:24 PM).</i>	➔	Exact time: : am/pm
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● **Wrap up**

INITIAL CONTACT- Talking to insured

Thank you for taking the time to answer my questions, we really appreciate your contribution. In the near future, you will receive an Exercise Progress Chart and a Falls Journal in which you can record any falls or near falls that may occur. You may also receive another telephone call shortly to set up an interview in your home, or we will be in touch with you couple of months to see how you are doing.

INITIAL CONTACT- Talking to proxy

Thank you for taking the time to answer my questions, we really appreciate your contribution. In the near future, *(name of insured)* will receive an Exercise Progress Chart and a Falls Journal in which you can record any falls or near falls that may occur. You may also receive another telephone call shortly to set up an interview in *(name of insured's)* home, or we will be in touch with you in a couple of months to see how *(name of insured)* is doing.

FINAL CONTACT- Talking to insured or proxy

Thank you for taking the time to answer my questions, we really appreciate your contribution to this important research Program. I want to thank you once again for participating in the Independent Living and Mobility Program your contributions may result in safer practices and home environments for older adults.

● **Clinical Summary: Provide an answer for each question**

44. Do you believe that the participant would have difficulty performing any of his/her IADL's and ADL's without assistance from another person due to an impairment?..... No

Yes

If Yes, due to cognitive impairment..... No Yes

If Yes, due to physical impairment..... No Yes

If Yes to either, explain _____

45. Did the participant appear apathetic or require prompting or motivating to answer questions or complete the interview?..... No

Yes

If Yes, explain: _____

46. Was there evidence of sad or depressed mood or flattened affect?..... No

Yes

If Yes, explain: _____

47. Did the participant have difficulty following directions?..... No

Yes

If Yes, explain: _____

48. Was the participant unable to answer any questions or did the participant refuse to answer any of the questions?..... No

Yes

If Yes, explain: _____

Assessor signature: _____

Date of interview: _____