

NATIONAL SURVEY OF OLDER AMERICANS ACT PARTICIPANTS

**LONGITUDINAL SURVEY INSTRUMENT: YEARS 2 AND 3
INFORMANT FOLLOWUP SURVEY**

DRAFT
AUGUST 2, 2017

Administration for Community Living
Administration on Aging
U.S. Department of Health and Human Services
Washington, D.C.

Introduction

I am calling from Westat, a research firm that is conducting the National Survey of Older Americans Act Participants funded by the Administration for Community Living/Administration on Aging. The survey is about the services that [NAME OF PARTICIPANT]¹ receives from [AGENCY NAME]. We have been unable to reach [NAME OF PARTICIPANT]. [He/she] participated in an earlier interview with Westat, and gave me your contact information in case we could not reach [him/her]. We have been unable to reach [NAME OF PARTICIPANT] and want to ask you a few questions about how to reach [him/her.]

A. RELATIONSHIP TO RESPONDENT IN THE LONGITUDINAL SURVEY

First, I need to verify your relationship to {NAME OF PARTICIPANT}.

A1. What is {you/his/her} relationship to {NAME OF PARTICIPANT}? Are you {his/her}...

- HUSBAND,..... 1
- WIFE,..... 2
- SON,..... 3
- SON-IN-LAW,..... 4
- DAUGHTER,..... 5
- DAUGHTER-IN-LAW,..... 6
- FATHER,..... 7
- MOTHER,..... 8
- BROTHER,..... 9
- SISTER,..... 10
- GRANDDAUGHTER,..... 11
- GRANDSON,..... 12
- NIECE,..... 13
- NEPHEW,..... 14
- A FRIEND OR NEIGHBOR OR ANOTHER PERSON,
OR..... 15
- OTHER RELATIVE..... 91
- (SPECIFY)_____
- REFUSED..... -7
- DON'T KNOW..... -8

A2. When was the last time you spoke to {NAME OF PARTICIPANT} either by phone or in-person?

|_|_| / |_|_|
Month Year

IF MORE THAN ONE MONTH GO TO A3; ELSE GO TO A4.

¹ [NAME OF PARTICIPANT] IS THE PERSON SAMPLED FOR THE LONGITUDINAL NSOAAP

In order to complete our records that we are unable to reach [NAME OF PARTICIPANT], I would like to ask the reason you are unable to reach {him/her}.

A3. What are the reasons that you have not had much contact with (NAME OF PARTICIPANT)?

- PARTICIPANT DIED..... 1 → **GO TO C**
- PERSON HAS A PHYSICAL LIMITATION
(E.G., HEARING LOSS, VISION, LOSS, ETC.).... 2
- PARTICIPANT MOVED..... 3
- OTHER..... -9
(SPECIFY)_____

A4. Please tell me how I may contact {NAME OF PARTICIPANT}?

Phone # _____

Address: _____

A5. Would {NAME OF PARTICIPANT} be able to respond to the survey?

- YES..... 1 → **GO TO CLOSING**
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

CLOSING: Thank you very much for your time. I will contact [name of participant] directly.

B. RECEIPT OF SERVICES

Since {NAME OF PARTICIPANT} is unable to answer questions for {himself/herself}, I would like to ask you a few questions. {NAME OF PARTICIPANT} agreed to answer these and other questions when we last spoke to {him/her}. The questions are about the services {he/she} received, {his/her} physical functioning, and health conditions. It will only take about 10 minutes for me to ask you the questions. Your participation is voluntary and you may skip any question that you do not want to answer. Your answers will be combined with the answers from other survey participants. The information you give me will only be seen by the research team, and will not be shared with anyone else. The information we collect from you and any other study participants will give the Administration for Community Living/Administration on Aging information on how well the services are working. May I continue?

B1. Is {NAME OF PARTICIPANT} still receiving services from [AGENCY NAME]?

- YES..... 1 → **GO TO SECTION E**
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8 } **GO TO B1a**

B1a. If "No," when did {NAME OF PARTICIPANT} stop receiving services?

/ /
 Month Day Year

B1b. If "No," why did the respondent stop receiving services?

- | | | |
|---|----|-------------------|
| A. MOVED TO ANOTHER LOCATION IN THE COMMUNITY OR OUT OF THE AREA..... | 1 |] GO TO SECTION E |
| B. MOVED TO A NURSING HOME BECAUSE OF ILLNESS/INJURY..... | 2 | |
| B. MOVED TO BE CLOSER TO RELATIVES..... | 3 | |
| C. MOVED TO ASSISTED LIVING BECAUSE OF ILLNESS/INJURY..... | 4 | |
| D. MOVED TO GROUP HOME, BOARD AND CARE HOME, ETC. BECAUSE OF ILLNESS/INJURY | 5 | |
| E. MOVED IN WITH A FRIEND OR RELATIVE BECAUSE OF ILLNESS OR INJURY..... | 6 |] GO TO SECTION D |
| F. RECEIVING SERVICES FROM ANOTHER AGENCY | 8 | |
| G. HAS A PRIVATE CAREGIVER IN THE HOME.... | 8 |] GO TO SECTION E |
| H. IN HOSPICE (IN HOME OR IN A FACILITY)..... | 9 | |
| I. DISSATISFIED WITH THE SERVICE..... | 10 | |
| J. OTHER?..... | 91 |] GO TO SECTION E |
| (SPECIFY) _____ | | |
| REFUSED..... | -7 | |
| DON'T KNOW..... | -8 | |

C. PARTICIPANTS WHO ARE NO LONGER LIVING

C1. What is [NAME OF RESPONDENT] date of death?

/
 Month Year

C2. Where was [NAME OF RESPONDENT] living at the time of death?

- OWN HOME..... 1
- RELATIVES HOME..... 2
- HOSPICE..... 3
- NURSING HOME..... 4
- ASSISTED LIVING..... 5
- GROUP HOME..... 6
- REFUSED..... -7
- DON'T KNOW..... -8
- Somewhere else..... -9
- SPECIFY _____

CLOSING 1: Thank you very much for answering my questions.

D. RESPONDENT RECEIVES SERVICES FROM ANOTHER AGENCY

We would like to learn more about the types of services that [NAME OF PARTICIPANT] receives. The next few questions ask about [him/her] receiving services from another agency.

D1. What was the reason {NAME OF PARTICIPANT} switched to another agency?

D2. Does {NAME OF PARTICIPANT} receive the same type of services as {he/she} did from [AGENCY NAME]?

- YES..... 1
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

D2a. If "No," please describe services received from the new agency.

E. ACTIVITIES OF DAILY LIVING

The next few questions are about {NAME OF PARTICIPANT}. To the best of your ability, please answer the following questions.

E1. Does {NAME OF PARTICIPANT} have difficulty getting around inside the home?
(PFDIFIC)

- YES..... 1
 - NO..... 2
 - REFUSED..... -7
 - DON'T KNOW..... -8
- } **GO TO E2**

E1a. {Does s/he} need the help of another person to perform this activity?
(PFDIFINBC)

- YES..... 1
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

E2. Does {s/he} have difficulty going outside the home, for example to shop or visit a doctor's office?
(PFDFOUC)

- YES..... 1
 - NO..... 2
 - REFUSED..... -7
 - DON'T KNOW..... -8
- } **GO TO E3**

E2a. Does {s/he} need the help of another person to perform this activity?
(PFDFOUBC)

- YES..... 1
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

E3. Does {NAME OF PARTICIPANT} have difficulty getting in or out of bed or a chair?
(PFBEDC)

- YES..... 1
 - NO..... 2
 - REFUSED..... -7
 - DON'T KNOW..... -8
- } **GO TO E4**

E3a. Does {s/he} need the help of another person to perform this activity?
(PFBEDBC)

- YES..... 1
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

E4. Does {s/he} have difficulty when taking a bath or shower?
(PFBATHC)

- YES..... 1
 - NO..... 2
 - REFUSED..... -7
 - DON'T KNOW..... -8
- } **GO TO E5**

E4a. Does {s/he} need the help of another person to perform this activity?
(PFBATHBC)

- YES..... 1
- NO..... 2
- REFUSED..... -7
- DON'T KNOW..... -8

E5. Does {NAME OF PARTICIPANT} have difficulty when dressing?
(PFDRESC)

- | | | |
|-----------------|----|-------------------|
| YES..... | 1 | } GO TO E6 |
| NO..... | 2 | |
| REFUSED..... | -7 | |
| DON'T KNOW..... | -8 | |

E5a. Does {s/he} need the help of another person to perform this activity?
(PFDRESBC)

- | | |
|-----------------|----|
| YES..... | 1 |
| NO..... | 2 |
| REFUSED..... | -7 |
| DON'T KNOW..... | -8 |

E6. Does {s/he} have difficulty when walking?
(PFWALKC)

- | | | |
|-----------------|----|-------------------|
| YES..... | 1 | } GO TO E7 |
| NO..... | 2 | |
| REFUSED..... | -7 | |
| DON'T KNOW..... | -8 | |

E6a. Does {s/he} need the help of another person to perform this activity?
(PFWALKBC)

- | | |
|-----------------|----|
| YES..... | 1 |
| NO..... | 2 |
| REFUSED..... | -7 |
| DON'T KNOW..... | -8 |

E7. Does {NAME OF PARTICIPANT} have difficulty eating?
(PFEATC)

- | | | |
|-----------------|----|-------------------|
| YES..... | 1 | } GO TO E8 |
| NO..... | 2 | |
| REFUSED..... | -7 | |
| DON'T KNOW..... | -8 | |

E7a. Does {s/he} need the help of another person to perform this activity?
(PFEATBC)

- | | |
|-----------------|----|
| YES..... | 1 |
| NO..... | 2 |
| REFUSED..... | -7 |
| DON'T KNOW..... | -8 |

E8. Does {s/he} have difficulty using the toilet or getting to the toilet?
(PFWCC)

YES..... 1
 NO..... 2
 REFUSED..... -7
 DON'T KNOW..... -8

E8a. Does {s/he} need the help of another person to perform this activity?
(PFWCBC)

YES..... 1
 NO..... 2
 REFUSED..... -7
 DON'T KNOW..... -8

F. Health Conditions

PROGRAMMER NOTE:
JUST DISPLAY CONDITIONS PREVIOUSLY CODED AS "NO."

F1. Now I would like to ask about medical conditions [NAME OF PARTICIPANT] may have. Has a doctor ever told [NAME OF PARTICIPANT] that {s/he has} had:

(PFDISA - PFDISU)	<u>YES</u>	<u>NO</u>	<u>RE</u>	<u>DK</u>	<u>N/A</u>
a. Arthritis or rheumatism?.....	1	2	-7	-8	-9
b. High blood pressure or hypertension?.....	1	2	-7	-8	-9
c. A heart attack, coronary heart disease, angina, congestive heart failure, or other heart problems?.....	1	2	-7	-8	-9
d. High cholesterol?.....	1	2	-7	-8	-9
e. Diabetes or high blood sugar?.....	1	2	-7	-8	-9
f. Allergies/asthma/emphysema/chronic bronchitis/other breathing and lung problems?.....	1	2	-7	-8	-9
g. Cancer or a malignant tumor, excluding minor skin cancer?.....	1	2	-7	-8	-9
h. Stroke?.....	1	2	-7	-8	-9
i. Anemia?.....	1	2	-7	-8	-9
j. Osteoporosis?.....	1	2	-7	-8	-9
k. Kidney disease?.....	1	2	-7	-8	-9
l. Eye or vision conditions such as glaucoma, cataracts, macular degeneration or other medical conditions?.....	1	2	-7	-8	-9

INTERVIEWER NOTE: THIS DOES NOT INCLUDE ONLY WEARS GLASSES OR CONTACTS.

(PFDISA - PFDISU)	YES	NO	RF	DK	N/A
m. Hearing problems?.....	1	2	-7	-8	-9
n. Emotional, nervous or psychiatric problems?.....	1	2	-7	-8	-9
o. Memory related disease such as Alzheimer's or dementia?.....	1	2	-7	-8	-9
p. Seizures or epilepsy?.....	1	2	-7	-8	-9
q. Parkinson's?.....	1	2	-7	-8	-9
r. Persistent pain, aching, stiffness or swelling around a joint?	1	2	-7	-8	-9
INTERVIEWER NOTE: INCLUDES BROKEN BONES; SPRAINED MUSCLES; BAD BACKS, KNEES, SHOULDERS, ETC.					
s. Multiple sclerosis?.....	1	2	-7	-8	-9
t. A serious problem with urinary incontinence?.....	1	2	-7	-8	-9
u. Something else?..... (SPECIFY) _____	1	2	-7	-8	-9

CLOSING 2: That is all the questions that I have for you today. Thank you very much for answering the questions.