Appendix F

OAHM Client Impact Evaluation Interview

Older Adults Home Modification Program
Client Impact Evaluation Interview[1]

Study ID			Visit	Today's Date	Form Completed By:	
Site ID	Field Team ID	Client ID		(mm/dd/yyyy)	Name	Job Title
			☐ Baseline ☐ Follow-Up			*(dropdown menu: OT, OTA, CAPS, other [Specify])*

OMB Control No. 2528-XXXX, expiration date XX/XX/2024. This form is designed to provide HUD with information about how effective its Older Adults Home Modification Grant Program is. The information you provide is voluntary. Your home can be enrolled in the program whether you decide to participate or not. The public reporting burden for collection of this information is estimated to be 20 minutes per response. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number

Grantee Guidance: Conduct this interview ***only with the client you have enrolled in the OAHM Program, i.e., the beneficiary receiving direct services from your program who has been identified as the client by the licensed occupational therapist (OT), or a licensed OT Assistant (OTA) or Certified Aging-in-Place Specialist (CAPS) whose work is overseen by a licensed OT.*** *Make sure this client's information has been correctly entered into Item 9 of the Client Eligibility Documentation Form. For each question, do not give "not answered" as an answer choice. Instead, gently probe for answers and only record "not answered" as a last resort.*

Section A. INFORMED CONSENT

We are evaluating HUD's older adults home modification program to see if we can improve it to better meet the needs of clients like you. I would like to read you this form *Show the client the informed consent*. **This form tells you about the Evaluation and how you can help with it. If you agree to participate in the Evaluation, I will have you sign this form. If you are physically unable to write your name, alternatives to a physical signature will be accepted. Then, I will ask you some questions about your health and activities.**

Taking part in the Evaluation is voluntary. You can choose not to take part in the Evaluation and still receive the Program's home modification services.

Go over the Consent Form

A.1 Did the client consent and sign the Form? ☐ Yes ☐ No

If A.1=Yes: **"Now I'll ask you questions about your health and activities. Some of the questions may seem repetitive. We need to ask the same questions in slightly different ways so we can compare our information with national and regional data."** *Go to Section B.*

If A.1=No: **"I'm sorry you chose not to participate in the Evaluation. Thank you for taking the time to meet with me today."** *End interview and complete Section B of the lost-to-project form, checking the box "Client declined to sign the Informed Consent."*
REDCap: Include a button to upload scan of signed informed consent to this form.

Section B: Sociodemographic Questions *Ask these questions only at the baseline visit*

[1] Code for this document: Black font=Question asked of the client; *Blue italics* = Instruction for the grantee; *yellow highlighted italics*: Instruction for REDCap programmer.

B.1 How long have you lived in this home? *Enter number between 0 and 100 or enter -1 if not answered* *(REDCap: Allow decimal places)*	____ Years
B.1a Thinking about your future years, are you more likely to move to a different community, move to a different residence within your current community, or stay in your current home and never move? *Check only one* (AARP Q5, 2020)	☐ Move to a different community ☐ Move into a different residence within my current community ☐ Stay in my current home and never move ☐ Not sure ☐ Not answered
B.1b How important is it for you to remain in this home for as long as possible? (AARP Q8, 2020)	☐ Extremely important ☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not at all important ☐ Not sure ☐ Not answered
B.1c How important is it for you to be able to live independently in this home as you age? (Q11, 2020)	☐ Extremely important ☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not at all important ☐ Not answered
B.2 What is your gender?	*List answer here*_____ ☐ Not answered
B.3 Are you Hispanic, Latino/a or Spanish origin? (Medicare HOS, 2020) *Hand client Answer Card B1. One or more categories may be selected*	☐ No, not of Hispanic, Latino/a, or Spanish origin ☐ Yes, Mexican, Mexican American, Chicano/a ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, another Hispanic, Latino/a, or Spanish origin ☐ Not answered
B.4 What is your race? (Medicare HOS, 2020) *Hand client answer card B2. One or more categories may be selected*	☐ White ☐ Black or African American ☐ American Indian or Alaska Native: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander _____ ☐ Other_____ ☐ Not answered

B.5 What is the highest grade of school you completed? *Check one box*	☐ less than 12 years ☐ high school graduate or GED ☐ some college or trade school ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate or Other Professional Degree ☐ Not answered
B.6 Who lives with you in this same home?	*REDCap: The following instruction applies to all answer choices except "No one else, Professional Caregiver, or Not Answered": For each person checked, open the "# ≥62____" box to record the number of people in that category who are 62 or older.* ☐ No one else, I live alone ☐ Child(ren) (Son/Daughter) # ≥62___ ☐ Spouse # ≥62___ ☐ Parent(s) # ≥62___ ☐ Grandchild(ren) # ≥62___ ☐ Other Relative(s) # ≥62___ ☐ Friend(s) # ≥62___ ☐ Professional Caregiver ☐ Not answered

Section C. HEALTH AND UNPLANNED HEALTHCARE USE

Do not provide "not answered" as an answer choice. Please gently try to obtain answers for all questions.

C.1 In general, compared with other people your age, would you say that your health is (Medicare HOS Q40):	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Not answered
C.2 What in-home healthcare services do you currently receive? *Check all that apply*	☐ Home visits from Occupational Therapist ☐ Home visits from Physical Therapist ☐ Home visits from Nurse ☐ Home visits from other health care provider ☐ None ☐ Not answered
C.3 What are some of the main medical issues you currently see a doctor for? *Do not read answer choices to the client. Check all that the client mentions.*	☐ Arthritis ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Difficulty in thinking or remembering things *Explain this refers to cognition issues; for example, confusion or memory loss that is happening more often or getting worse, such as forgetting how to do things you've always done or forgetting things that you would normally know how to do. (CDC)* ☐ COPD or other chronic respiratory issue ☐ Vision issue

	(Open this dropdown list if vision box is checked: Client's wording for vision issue: ☐ blind ☐ legally blind ☐ limited vision ☐ low vision ☐ partially sighted Other (Specify): ☐ Hearing issue *(Open this dropdown list if hearing box is checked:* Client's wording for hearing issue: ☐ hard of hearing ☐ hearing loss ☐ deaf ☐ partially deaf ☐ Other (Specify): ☐ Speech issue *(Open this dropdown list if hearing box is checked:* Client's wording for hearing issue: ☐ stuttering ☐ stammering ☐ trouble speaking or talking ☐ voice problems ☐ Other (Specify): ☐ Chronic problems with legs or feet ☐ Other medical issues (specify) _____ ☐ None ☐ Not answered
C.4 How much does pain interfere with your normal everyday activities? *Hand client answer Card C and explain the scale, i.e., 1=does not interfere, 10=interferes completely*	Answer *(between 1 and 10)*: _____

	Always	**Frequently**	**Sometimes**	**Rarely**	**Never**	**Not answered**
C.5 How often do you use a:						
C.5a Wheelchair to help you move inside your home and on your property?	☐	☐	☐	☐	☐	☐
C.5b Walker to help you move inside your home and on your property?	☐	☐	☐	☐	☐	☐
C.5c Cane to help you move inside your home and on your property?	☐	☐	☐	☐	☐	☐

"This next set of questions concern major medical events which occurred between *[REDCap: insert date 12 months prior to baseline or follow-up visit date]* and *[REDCap: provide date of baseline or follow-up visit]*. Major medical events are injuries or illnesses that happen unexpectedly and are serious enough that you need some sort of immediate, unplanned medical care. Unplanned medical care may include calling 911, the fire department, or ambulance services; or visiting an emergency room or urgent care facility."

C.6 In the past year, have you had a major medical event requiring you to have unplanned medical care calls or visits?	☐ No *(Go to Section D)* ☐ Yes ☐ Not answered *(Go to Section D)*
C.6.a. How many unplanned medical care calls or visits	☐ 1

did you make in the past year?	☐ 2 ☐ 3 ☐ 4 or more times ☐ Not answered *(Go to Section D)*
Section C.6_1: Details of the FIRST unplanned medical care call or visit. Complete this block If C.6=Yes and C.6a≥1, up to a value of 4. Replace "first" with "second," "third," and "fourth," as appropriate	
C.6_1. For your *[FIRST]* unplanned major medical event, did emergency medical services come to your home?	☐ Yes ☐ No ☐ Not answered
C.6_2. For your *[FIRST]* unplanned major medical event, did you GO TO an Emergency Room or Urgent Care Center? *Check all that apply. For example, if the client went to the urgent care and was then sent to ER, check both. If the client went to their primary care physician who treated them and sent them home, check "neither."*	☐ Emergency Room ☐ Urgent Care Center ☐ Neither *(If C.6.a>1, go to C.6_1_**SECOND**; otherwise, if C.6a=1, go to Section D)* ☐ Not answered
C.6_2a. What was the reason for this *[FIRST]* unplanned visit to the ER or Urgent Care Center? *Check all that apply.*	☐ Fall. Did the fall occur in this home or on the surrounding property? ☐ Yes ☐ No ☐ Injury. Did the injury occur in this home or on the surrounding property? ☐ Yes ☐ No ☐ Stroke or Cardiac Event ☐ Asthma Attack or Respiratory Event ☐ Diabetic Shock or Blood Sugar Event ☐ Reason not already mentioned SPECIFY:_____ ☐ Not answered
C.6_2b. Did you spend at least one night in the hospital as a result of your *[FIRST]* unplanned major medical event?	☐ Yes ☐ No *(If C.6a>1, go to next unplanned medical care call or visit OR if C.6a=1, go to Section D)* ☐ Not answered *(If C.6a>1, go to next unplanned medical care call or visit OR if C.6a=1, go to Section D)*
C.6_2c. How many nights were you in the hospital as a result of your *[FIRST]* unplanned major medical event? *Enter # of nights between 1 and 250 or enter -1 if not answered. If the person gives their answer in months, convert to nights using a conversion factor of 30.42 days/month.*	_____
C.6_2d. When you left the hospital after your major medical event, did you have to stay somewhere other than your current home (e.g., relative's home, rehab facility, nursing home) to recover before returning to your home?	☐ Yes ☐ No *(Go to Section C.6_2e)* ☐ Not answered
C.6_2d.i. Where did you stay during your recovery from your unplanned major medical event?	☐ Nursing home ☐ Rehabilitation center ☐ Friend or relative's home *(If C.6a>1, go to next unplanned medical care call or visit OR if C.6a=1, go to Section D)* ☐ Another location not yet mentioned Specify: ___ ☐ Not answered *(If C.6a>1, go to next unplanned*

	medical care call or visit OR if C.6a=1, go to Section D)
C.6_2d.ii. How many nights did you stay there? *Enter # of nights between 0 and 250 or enter -1 if not answered. If the person gives their answer in months, convert to nights using a conversion factor of 30.42 days/month. REDCap: List an error message if they say 0 nights*	___
C.6_2e. How concerned were you about returning to your home after this unplanned major medical event?	☐ Extremely concerned ☐ Very concerned ☐ Somewhat concerned ☐ Not very concerned ☐ Not at all concerned ☐ Not answered

Section D: EuroQOL (EQ-5D-3L, USA [English] ©1998 EuroQol Group EQ-5D™ is a trademark of the EuroQol Group)

Hand the participant PAGE 1 of the laminated version of EQ-5D-3L. **"Here are some questions for you to answer. By placing a checkmark in or pointing to one box in each group on the paper, please indicate which statements best describe your own health state today. Then hand the paper back to me."** *Each time the person tells you or points to an answer, record it below. Only one answer is permitted per question.*

D.1. Mobility	☐ I have no problems in walking about ☐ I have some problems in walking about ☐ I am confined to bed
D.2. Self-Care	☐ I have no problems with self-care ☐ I have some problems washing or dressing myself. ☐ I am unable to wash or dress myself
D.3. Usual activities (e.g., work, study, housework, family, or leisure activities)	☐ I have no problems with performing my usual activities ☐ I have some problems with performing my usual activities ☐ I am unable to perform my usual activities
D.4. Pain/Discomfort	☐ I have no pain or discomfort ☐ I have moderate pain or discomfort ☐ I have extreme pain or discomfort
D.5. Anxiety/Depression	☐ I am not anxious or depressed ☐ I am moderately anxious or depressed ☐ I am extremely anxious or depressed
D.6 *Hand laminated page 2 of EQ-5D-3L to the person and read:* **"We would like to know how good or bad your health is TODAY. This scale is numbered from 0 to 100. 100 means the best health you can imagine, 0 means the worst health you can imagine. Please [point] on the scale to indicate how your health is today."** *The participant can "draw" with a finger from the "Your own health state today" box to the point on the scale. Record this value between 0 and 100.*	___ Score

Section E: Life-Space Assessment (UAB Study of Aging Life-Space Assessment™ 2008): *Read the frequency choices when asking about each level.*

These questions refer to your activities just within the past month			
During the past four weeks, have you been to...	**Response**	**How often did you get there?**	**Did you use aids or equipment? Did you need help from another person?**
E.1 Other rooms of your home besides the room where you sleep?	E.1A ☐ YES ☐ NO	E.1B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.1C ☐ personal assistance ☐ equipment only ☐ no equipment or personal assistance
E.2 An area outside your home such as your porch, deck or patio, hallway (of an apartment building) or garage, in your own yard or driveway?	E.2A ☐ YES ☐ NO	E.2B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.2C ☐ personal assistance ☐ equipment only ☐ no equipment or personal assistance
E.3 Places in your neighborhood, other than your own yard or apartment building?	E.3A ☐ YES ☐ NO	E.3B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.3C ☐ personal assistance ☐ equipment only ☐ no equipment or personal assistance
E.4 Places outside your neighborhood, but within your town?	E.4A ☐ YES ☐ NO	E.4B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.4C ☐ personal assistance ☐ equipment only ☐ no equipment or personal assistance
E.5 Places outside your town?	E.5A ☐ YES ☐ NO	E.5B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.5C ☐ personal assistance ☐ equipment only ☐ no equipment or personal assistance

Section F: The Patient Health Questionnaire (PHQ-9) (Spitzer et al 1994)

Hand participant answer Card F1 and read the answer choices before asking the question F.1. **"Over the past two weeks, how often have you been bothered by any of the following problems:**	**Not at all (0)**	**Several Days (1)**	**More than half the days (2)**	**Nearly Every Day (3)**
F.1 Little interest or pleasure doing things?	☐	☐	☐	☐
F.2 Feeling down, depressed, or hopeless?	☐	☐	☐	☐
F.3 Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
F.4 Feeling tired or having little energy?	☐	☐	☐	☐
F.5 Poor appetite or overeating?	☐	☐	☐	☐
F.6 Feeling bad about yourself or that you're a failure or have let yourself or your family down?	☐	☐	☐	☐

F.7 Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
F.8 Moving or speaking so slowly that other people could have noticed? Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
F.9 Thoughts that you would be better off dead, or of hurting yourself?	☐	☐	☐	☐
If the participant answered "not at all" for all of F.1-F.9, do not ask F.10 and record the "not difficult at all" answer for F.10. Otherwise, hand the participant ***Card F2***				
F.10 If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult			

If any of questions F.1 through F.10 were not answered, go back to try to obtain answers to all questions.

Section G: MEDICARE HEALTH OUTCOMES SURVEY ACTIVITIES OF DAILY LIVING QUESTIONS (US Centers for Medicare and Medicaid, 2020, https://www.hosonline.org/globalassets/hos-online/survey-instruments/hos_2020_survey_English.pdf)

HAND THE CLIENT CARD G: **"For a previous form, you were asked to indicate whether you have any limitations in your activities. We are now going to ask a few additional questions in this area."**

"Because of a health or physical problem, do you have difficulty doing the following activities *without special equipment or help from another person*?"	**No, I do not have difficulty**	**Yes, I have difficulty**	**I am unable to do this activity**
G.1 Bathing	☐	☐	☐
G.2 Dressing	☐	☐	☐
G.3 Eating	☐	☐	☐
G.4 Getting in or out of chairs	☐	☐	☐
G.5 Walking	☐	☐	☐
G.6 Using the toilet	☐	☐	☐

Section H: MEDICARE HEALTH OUTCOMES SURVEY INSTRUMENTAL ACTIVITIES OF DAILY LIVING (US Centers for Medicare and Medicaid 2020, https://www.hosonline.org/globalassets/hos-online/survey-instruments/hos_2020_survey_English.pdf)

HAND THE CLIENT CARD H.

"Because of a health or physical problem, do you have difficulty doing the following activities?"	**No, I do not have difficulty**	**Yes, I have difficulty**	**I don't do this activity**
H.1 Preparing meals	☐	☐	☐
H.2 Managing money	☐	☐	☐
H.3 Taking medication as prescribed	☐	☐	☐

Save and close this form. While still in the home, open and complete the Home Hazard Checklist. Complete section I of this interview after leaving the home.

Section I: Staff Notes and Comments

I.0 Length of the interview in minutes: _____

(REDCap: Provide questions I.1 through I.4 only on the baseline form.)

Grantee Guidance: Questions I.1 through I.4 are optional. Answer these questions yourself after you leave the client's home. In general, this information may help other staff determine steps they may need to take when interacting with the client.

I.1 Did the client have frequent difficulty comprehending the questions in the interview (e.g., client had difficulty hearing, concentrating, or required frequent repetition of questions)?	☐ No ☐ Yes
I.1a If yes, please explain	
I.2 Did the client give unusual or irrelevant answers to questions (i.e., used wrong response options, made comments that had nothing to do with the interview question, incoherent statements)?	☐ No ☐ Yes
I.2a If yes, please explain.	
I.3 Did the client have frequent difficulty recalling information (i.e., recent events, prior questions, basic information about himself/herself such as age or address)?	☐ No ☐ Yes
I.3a If yes, please explain.	
I.4 Additional Interviewer Comments	

CLIENT IMPACT EVALUATION ANSWER CARDS

IMPACT EVALUATION INTERVIEW CARD B1

No, not of Hispanic, Latino/a, or Spanish origin

Yes, Mexican, Mexican American, Chicano/a

Yes, Puerto Rican

Yes, Cuban

Yes, another Hispanic, Latino/a, or Spanish origin

IMPACT EVALUATION INTERVIEW ANSWER CARD B2

(may choose more than one)

- White
- Black or African American
- American Indian or Alaska Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian: _____
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander: _____
- Other: _____

IMPACT EVALUATION INTERVIEW CARD C: Pain Interference

Card

Scale of 1 to 10:

1--------2--------3--------4--------5--------6--------7--------8--------9--------10

Does Not Completely Interfere

Moderately Interferes

Interfere

IMPACT EVALUATION INTERVIEW ANSWER CARD F1

Not at all

Several days

More than half the days

Nearly every day

IMPACT EVALUATION INTERVIEW ANSWER CARD F2

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

IMPACT EVALUATION INTERVIEW ANSWER CARD G

No, I do not have difficulty

Yes, I have difficulty

I am unable to do this activity

IMPACT EVALUATION INTERVIEW ANSWER CARD H

No, I do not have difficulty

Yes, I have difficulty

I don’t do this activity