**Evaluation of the Older Adults Home Modification Grant Program**
**OMB #2528-NEW**

# A. Justification

## 1. Circumstances Necessitating the Data Collection

*Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.*

The U.S. Department of Housing and Urban Development's (HUD) Office of Lead Hazard Control and Healthy Homes (OLHCHH) is launching a new grant program, the Older Adult Home Modification Program (OAHMP). The goal of this home modification program is to help low-income older adults "age-in-place" in their own homes by funding low-barrier, high-impact home modifications that reduce clients' risk of falling, enhance their general safety, increase their homes' accessibility, and improve their functional abilities. OLHCHH will award OAHMP grants to approximately 32 experienced organizations (non-profit organizations, state or local governments, or public housing agencies) that make modifications and limited repairs to the homes of eligible adults.

The Office of Policy Development and Research (PD&R) will evaluate the implementation and impact of this new program. This document represents a new Information Collection Request (ICR) to the Office of Management and Budget (OMB), requesting approval for up to three years of data collection for this evaluation, to begin in 2021. Through a competitive procurement, PD&R has chosen Healthy Housing Solutions, Inc. ("the Contractor"), a small business, as its contractor for the purposes of conducting this Evaluation.

The federal government has a long-term interest in reducing the costs of services to the elderly by enabling them to remain safely in their homes. In 2018, 55% of skilled nursing facility costs were paid by Medicaid, Medicare, and the Veterans Administration.[1] In 2016, total long-term care spending—including public, out-of-pocket, and other private spending—was $366 billion (12.9% of all U.S. personal health care spending), almost two-thirds of which was paid by Medicaid and Medicare.[2] Acute-care costs, i.e., costs associated with short term, immediate medical care for serious illnesses (e.g., heart attack, abdominal pain/spasms) or traumatic injuries (e.g., fall-related broken bones), are also burdensome. Each year, approximately $50 billion is spent on nonfatal fall injuries, $29 billion of which are paid by Medicare and $9 billion by Medicaid.[3]

[1] U.S. Centers for Medicare and Medicaid Services. Historical National Health Expenditure Data. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.

[2] Congressional Research Service. 2018, August 22." Who pays for long-term services and supports?" *In Focus* www.crs 7-5700. Retrieved from https://fas.org/sgp/crs/misc/IF10343.pdf

[3] Florence, Curtis S., Gwen Bergen, Adam Atherly, Elizabeth Burns, Judy Stevens, and Cynthia Drake.2018, April. "Medical costs of fatal and nonfatal falls in older adults," *Journal of the American Geriatrics Society* 66(4):693-698. doi: 10.1111/jgs.15304.

Researchers and policymakers have found that limitations in multiple activities of daily living (ADLs),[4] such as daily self-care, or instrumental activities of daily living (IADLs),[5] such as shopping, are the leading modifiable predictor of nursing home admission.[6,7] Low-income older adult clients often lack the resources necessary to improve their housing functionality and to compensate for the increased difficulty of performing ADLs that comes with advancing age.

Program models for home modifications targeting both housing (environmental) and health risk factors are limited, even though disability often results from the combination of both. Low-income older adults have a particular need for interventions addressing both housing and individual health risk factors as they have higher rates of disability,[8,9,10] pain,[11] and depression;[12, 13] less access to primary care;[14] and increased likelihood of living in substandard housing.[15]

Research demonstrates, under certain conditions, home modification can significantly reduce the risk of falling among community-dwelling elderly persons. A 2015 systematic literature review concluded a 'high intensity' environmental assessment delivered by an Occupational Therapist (OT) and home modifications for "high risk" elderly adults were clinically effective in preventing

[4] ADLs are defined as eight activities essential to daily self-care: walking, bathing, upper and lower body dressing, eating, using the toilet, transferring in and out of a bed or chair, and grooming. Centers for Medicare and Medicaid Services, Medicare Current Beneficiary Survey 2018 Methodology Report, Page 126. Retrieved from: https://www.cms.gov/files/document/2018-mcbs-methodology-report.pdf

[5] IADLs are defined as eight independent living skills: using a telephone, shopping, preparing food, housekeeping, washing laundry, traveling independently, taking medications independently, and managing finances independently. Ibid., Page 126.

[6] Gaugler Joseph E., Sue Duval, Keith A. Anderson, Robert L. Kane. 2007, June 19. "Predicting nursing home admission in the U.S.: a meta analysis," *BMC Geriatrics* 7(13). doi: 10.1186/1471-2318-7-13.

[7] Salive M.E, K.S. Collins, D.J. Foley, and L.K George. 1993, December. "Predictors of nursing home admission in a biracial population," *American Journal of Public Health* 83(12):1765–1767. doi:10.2105/ajph.83.12.1765.

[8] Thorpe, Roland J. Jr., Olivio J. Clay, Sarah L. Szanton, Jason C. Allaire, and Keith E. Whitfield. 2011, November. "Correlates of mobility limitation in African Americans," *The Journals of Gerontology. Series A, Biological sciences and medical sciences* 66(11):1258–63. doi: 10.1093/gerona/glr122.

[9] Thorpe, Roland J. Jr., Sarah L. Szanton, Caryn N. Bell, and Keith E. Whitfield. 2013, Winter. "Education, income and disability in African Americans," *Ethnicity and Disease* 23(1):12–7. PMID: 23495616.

[10] Minkler, Meredith, Esme Fuller-Thomson, and Jack M. Guralnik. 2006, August. "Gradient of disability across the socioeconomic spectrum in the United States," *New England Journal of Medicine* 355(7):695–703. doi: 10.1056/NEJMsa044316.

[11] Green, Carmen R., Karen O. Anderson, Tamara A. Baker, Lisa C. Campbell, Sheila Decker, Roger B. Fillingim, Donna A. Kalauokalani, Kathyrn E. Lasch, Cynthia Myers, Raymond C. Tait, Knox H. Todd, and April H. Vallerand. 2003, September. "The unequal burden of pain: confronting racial and ethnic disparities in pain," *Pain Medicine* 4(3):277–94. doi: 10.1046/j.1526-4637.2003.03034.x.

[12] Barry, Lisa C., Roland J. Thorpe Jr., Brenda W. J. H. Penninx, Kristine Yaffe , Dorothy Wakefield, Hilsa N. Ayonayon, Suzanne Satterfield, Anne B. Newman, and Eleanor M. Simonsick. 2014, July. "Race-related differences in depression onset and recovery in older persons over time: the health, aging, and body composition study," *The American Journal of Geriatric Psychiatry* 22(7):682-91. doi: 10.1016/j.jagp.2013.09.001.

[13] Aneshensel, Carol S., Richard G. Wight, Dana Miller-Martinez, Amanda L. Botticello, Arun S. Karlamangla, and Teresa E. Seeman. 2007, January. "Urban neighborhoods and depressive symptoms among older adults," *The Journals of Gerontology. Series B, Psychological sciences and social sciences* 62(1):S52–9. doi: 10.1093/geronb/62.1.s52.

[14] Counsell, Steven R., Christopher M. Callahan, Daniel O. Clark, Wanzhu Tu, Amna B. Buttar, Timothy E. Stump, and Gretchen D Ricketts. 2007, December. "Geriatric care management for low-income seniors: a randomized controlled trial," *JAMA* 298(22):2623–33. doi: 10.1001/jama.298.22.2623.

[15] Golant, Stephen M. 2008. "Low-income elderly homeowners in very old dwellings: the need for public policy debate," *Journal of Aging and Social Policy* 20(1):1–28. doi: 10.1300/j031v20n01_01.

falls. The researchers defined "high risk" as community-dwelling adults aged 65 and older with one or more of the following risk factors: one or more falls in the previous year, a recent hospital admission, a chronic health condition, or visual impairment. The authors concluded OT-led interventions were effective because OTs focused on the impact of the environment on an individual's function and considered personal, environmental, and activity-related fall risk factors. Protocols that did not use an OT to conduct the assessment and/or that did not limit the interventions to high-risk adults did not show the same level of effectiveness.[16]

Johns Hopkins University School of Nursing program's Community Aging in Place – Advancing Better Living in Elders (CAPABLE) is a core program model for the OAHMP. This model employs a team, comprised of an OT, a registered nurse, and a home modifier (i.e., a contractor or a maintenance person hired by the grantee), to conduct an assessment and implement home modifications to improve the functional ability of clients. A recent randomized controlled trial of the CAPABLE model with low-income community-dwelling adults aged 65 and older who lacked cognitive impairments and had self-reported difficulty with ADLs or two or more IADLs found the intervention group experienced a significant reduction in disability (ADLs and IADLs) compared to the control group.[17]

However, OAHMP grantees may use other program models if approved by OLHCHH. Possible differences in program models indicate a need to document the health and cost impact of an older adult home modification program over a broader set of program models. While housing modification programs are currently available in many local communities, many are limited in their repair options, lack an evidence base, and have not documented their impact on reducing older adults' ADL/IADL limitations and improving their ability to remain in their homes.

These data indicate HUD has the need to develop, test, and implement creative, practical strategies to promote safe and healthy aging in place that can decrease older adult healthcare costs. This Evaluation will improve HUD's ability to design, manage, and sustain programs for older adult home modifications, particularly those targeted to owner-occupied homes.

### Legal Authority for the Data Collection

Authority and funding for the OAHMP are provided by the Consolidated Appropriations Act, 2019, approved February 15, 2019 (Public Law 116-6); the Further Consolidated Appropriations Act, 2020, approved December 20, 2019 (Public Law 116-94); and the Consolidated Appropriations Act, 2021, approved December 27, 2020 (Public Law 116-260).[18]

The authority for PD&R and OLHCHH to conduct evaluation is as follows.

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[16] Pighills Alison, Claire Ballinger, Ruth Pickering, and Satyan Chari. 2015, November. "A critical review of the effectiveness of environmental assessment and modification in the prevention of falls amongst community dwelling older people," *British Journal of Occupational Therapy* 79(3):133-143. doi./10.1177/0308022615600181.

[17] Szanton, Sarah L, Qian-Li Xue, Bruce Leff, Jack Guralnik, Jennifer L. Wolff, Elizabeth K. Tanner, Cynthia Boyd, Roland J. Thorpe Jr., David Bishai, and Laura N. Gitlin.(2019, February. "Effect of a biobehavioral environmental approach on disability among low-income older adults: a randomized clinical trial." *JAMA Internal Medicine* 179(2):204-211. doi: 10.1001/jamainternmed.2018.6026.

[18] U.S. Department of Housing and Urban Development. Office of Lead Hazard Control and Healthy Homes. Older Adults Home Modification Program, FR-6400-N-69, 5/18/2021. Page 12. Retrieved at https://www.hud.gov/sites/dfiles/SPM/documents/OlderAdultModificationProgramupdated4.12.21_FR-6400-N-69%2819%29.pdf.

HUD's stated mission is:

> …to create strong, sustainable, inclusive communities and quality affordable homes for all. HUD is working to strengthen the housing market to bolster the economy and protect consumers; meet the need for quality affordable rental homes*; utilize housing as a platform for improving quality of life*; build inclusive and sustainable communities free from discrimination, and transform the way HUD does business.[19] [Emphasis added.]

HUD's authority to conduct research related to the housing needs of older adults is codified in the U.S. Code at 12 U.S.C.§ 1701z-1[20] and § 1701z-6.[21] (See appendix A)

Section 1701z-1 authorizes:

> …such programs of research, studies, testing, and demonstration relating to the mission and programs of the Department as [the Secretary] determines to be necessary and appropriate.

Section 1701z-6 (a) further authorizes:

> Special demonstrations of housing design, structure, facilities, and amenities to meet needs of *elderly*, handicapped, etc.; contracts, grants, and assistance by Secretary.…In carrying out activities under section 1701z-1 of this title, the Secretary may undertake special demonstrations to determine the housing design, the housing structure, and the housing-related facilities, and amenities most effective or appropriate to meet the needs of groups with special housing needs including the *elderly*, the handicapped, the displaced, single individuals, broken families, and large households. For this purpose, the Secretary is authorized to enter into contracts with, to make grants to, and to provide other types of assistance to individuals and entities with special competence and knowledge to contribute to the planning, development, design, and management of such housing. [Emphases added.]

Subsection 1701z-6(d) authorizes:

> Evaluation of demonstration. In carrying out this section, the Secretary shall include, as part of any demonstration, an evaluation of the demonstration to cover the full experience involved in planning, development, and occupancy.

PD&R supports HUD's mission by informing:

> …HUD policy development and implementation to improve life in American communities through conducting, supporting, and sharing research, surveys, demonstrations, program evaluations, and best practices. Within HUD, PD&R is responsible for nearly all program evaluations.[22]

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[19] U.S. Department of Housing and Urban Development. [n.d.] Mission. Retrieved at https://www.hud.gov/about/mission.

[20] U.S. Code at 12 U.S.C. §1701z-1 https://uscode.house.gov/view.xhtml?req=(title:12%20section:1701z-1%20edition:prelim).

[21] U.S. Code at 12 U.S.C. §1701z-6 https://uscode.house.gov/view.xhtml?req=(title:12%20section:1701z-6%20edition:prelim).

[22] Office of the Assistant Secretary for Policy Development and Research, HUD. HUD Program Evaluation Policy—Policy Statement. [Docket No. FR–5985–N–01] Federal Register / Vol. 81, No. 234 / Tuesday, December 6, 2016, 87949-50.

OHHLHC further supports HUD's mission by advancing:

> …the research agenda on the effects, evaluations and control of lead and *other health and safety hazards* in housing and the impacts on resident health."[23] [Emphasis added]

Both PD&R's and OLHCHH's agendas identify research into home modifications that will enable the elderly to remain in their homes as a priority.

## 2. Use of Collected Data

*Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.*

### Study Overview

The Evaluation of the OAHMP grants will assess the OLHCHH grant program's effectiveness. HUD's purpose for the OAHMP is

> …to assist experienced nonprofit organizations, state and local governments, and public housing authorities in undertaking comprehensive programs that make safety and functional home modifications, and limited repairs to meet the needs of low-income elderly homeowners. The goal of the home modification program is to enable low-income elderly persons to remain in their homes through low-cost, low barrier, high impact home modifications to reduce older adults' risk of falling, improve general safety, increase accessibility, and to improve their functional abilities in their home. This will enable older adults to remain in their homes, that is, to "age in place," rather than move to nursing homes or other assisted care facilities.[24]

Under the terms of the OLHCHH OAHMP NOFO, grantees are required to collaborate with PD&R "on that Office's evaluation of the impact of the OAHMP, and any other HUD research on the program." The NOFO specifies:

> Grantees must cooperate fully with any research or evaluation sponsored by HUD or another government agency associated with this grant program, including preservation of project data and records and compiling requested information in formats provided by the researchers, evaluators or HUD. This may include the compiling of certain relevant local demographic, dwelling unit, and participant data not contemplated in the original proposal. Participant data must be subject to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)…. [For the program] ... HUD does not expect research to be conducted that could affect human subjects…. [Grantees] must collect, maintain, and provide to HUD the data necessary to document and evaluate grant program outputs and outcomes. HUD will contract with an organization to coordinate

[23] U.S. Department of Housing and Urban Development. 2019, May. Strategic Plan: 2018-2022. Page 19. Retrieved at https://www.hud.gov/sites/dfiles/SPM/documents/HUDSTRATEGICPLAN2018-2022.pdf

[24] U.S. Department of Housing and Urban Development. Office of Lead Hazard Control and Healthy Homes. Older Adults Home Modification Program, op. cit. Pages 3-4.

evaluation activities, including the capturing of outcome data.[25]

OLHCHH developed an OAHM "Program Services Model" for this grant program that "incorporates two core concepts: first, as people age, their needs change, and they may need adaptations to their physical environment to live safely at home; second, for any intervention to have the highest impact, the individual's personal goals and needs must be a driver in determining the actual intervention."[26] The Program Services Model components for grantees are summarized as follows:

1. An initial interview and in-home assessment is conducted by a licensed Occupational Therapist (OT), licensed OT Assistant (OTA), or Certified Aging-in-Place Specialist (CAPS), with the latter two working under the supervision of a licensed OT. The OT, OTA, or CAPS will conduct the initial interview with the client and care takers (if available) in their home and assess the home for safety hazards, including the client's fall risk, and/or the client's functional abilities with ADLs and IADLs.
2. A work order is created by the OT or by a licensed OTA or CAPS whose work under the grant is supervised by a licensed OT. With the client's consent, the OT, OTA, or CAPS will prioritize necessary home modifications and complete a work order and any additional specifications.
3. Home modification work is conducted by a licensed contractor qualified to perform the required work, in accordance with local and state regulations.
4. An in-home follow-up assessment and inspection is conducted by the licensed OT, who will also train the client in the safe and proper use of adaptive equipment and home modifications. During this visit, the OT will also inspect the home modification work to ensure it meets the work order requirements and complete a new work order for any needed adjustments.

Grantees who receive competitive awards from OLHCHH will manage recruitment of clients and services delivered by the OAHMP. They will be selected according to their administrative structures, urban and rural status of the area they will serve, capacity, and other criteria stated in the NOFO.

Grantees will specify their recruitment and service delivery methods in their individual grantee Management and Work Plans, which will be submitted to OLHCHH for review and approval prior to the start of their OAHMP work. Grantees will report progress toward meeting their objectives to OLHCHH through mechanisms approved under OMB Control Number 2539-0008.

PD&R will have no role in these programmatic decisions. OLHCHH will share with PD&R the grantee locations, individual grant program names, contacts, approved work plans, and quarterly reports. Approved work plans and quarterly reports submitted to OLHCHH will be vetted by PD&R prior to sharing with the Contractor. PD&R will provide this information, as appropriate, to the Contractor as context for grantees' implementation decisions and progress solely for the purposes of this Evaluation. These data are needed for evaluation purposes. Grantees will provide

[25] Ibid. Pages 21-22.
[26] Ibid. Page 4.

all other Evaluation data to the Contractor using the forms described in more detail later in this section.

### Study Objectives

The Evaluation's main objectives are to assess how the grants were implemented by the OAHMP grantees (Process Evaluation) and to track health and physical function outcomes of seniors whose homes have been modified (Impact Evaluation). The Process Evaluation will assess (1) how grantees implement their program, describing challenges, barriers, and successes they encounter; and (2) clients' opinions of the grantee's process and the home modifications they received. The Impact Evaluation will determine how the modifications affected the older adult clients whose homes were modified by measuring changes—between baseline and six- to nine-month post-home modification—in clients' (1) difficulties with ADLs and IADLs; (2) frequency of at-home falls; (3) quality of life; (4) unplanned emergency department (ED) and hospital visits; (5) tenure in their homes; (6) falls efficacy (i.e., the confidence an older adult has that they can do various activities without falling); (7) mobility inside and outside the home; (8) depression; and (9) pain interference with daily activities.[27]

Table 1 and Table 2 identify PD&R's key evaluation objectives for the Process and Impact Evaluations.

| Table 1. Process Evaluation Objectives |
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| 1. Determine if grantees implement their programs according to OLHCHH's grant requirements. |
| 2. Determine how OAHMP implementation varied by geography, building characteristics, housing type, demographics, grantee management capacity, or other characteristics of the sites, grantees, or clients. |
| 3. Determine how OAHMP implementation evolved over the three-year grant period, examining grantees' annual statistics such as number of people enrolled, number of homes modified, changes in recruitment strategies (including incentives, if any), changes in the types of home modifications performed, changes in methods grantees used to provide home modification services, and average home modification cost per home. |
| 4. Summarize major lessons learned by grantees as they initiated, implemented, and fine-tuned their programs, including the operational challenges, barriers, and successes they encountered and how they overcame the challenges and barriers. |
| 5. Summarize grantee plans to sustain or scale up the OAHMP after the grant period ends. |
| 6. Identify similarities and differences in how grantees chose to staff and manage the programs at their locations, including housing modification contractor support. |
| 7. Compare and contrast the scopes of home modification services offered by the grantees. |
| 8. Compare and contrast grantees' reasons for applying to the program. |

[27] The assessment period of six- to nine-months post-modification is required under the PD&R solicitation for this Evaluation. 2020, August 25. Amended 86614620Q00009 – FY20 Home Mod Study Solicitation. Survey of Recipients. Page 10. Retrieved from: https://sam.gov/opp/3d953aca9f88435faf816f314d870707/view. It is also supported by prior PD&R funded research related to the ability to detect long-term changes in ADLs and IADLs after implementation of the Community Aging in Place – Advancing Better Living in Elders (CAPABLE) approach which is a core program model for the OAHMP. Breysse J, Dixon S, Wilson J, and Szanton S. 2021, September 2. "Aging gracefully in place: An evaluation of the capability of the CAPABLE© approach." *Journal of Applied Gerontology*. 7334648211042606. doi: 10.1177/07334648211042606. Epub ahead of print. PMID: 34474609.

| Table 1. Process Evaluation Objectives |
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| |
| 9. Summarize clients' perception of the health and housing benefits or disadvantages offered by the OAHMP. |

| Table 2. Impact Evaluation Objectives |
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| 1. Determine whether clients' mean self-reported ADL difficulties score and mean IADL difficulties score changed between baseline and follow-up. |
| 2. Determine whether clients' self-reported difficulties with certain ADLs and IADLs (i.e., those listed in the Medicare Health Outcomes Survey (Medicare HOS) differ from those reported by a matched Medicare HOS group over approximately the same time period.[28] |
| 3. Determine whether clients' mean number of self-reported falls changed between baseline and follow-up. |
| 4. Determine whether clients' mean self-reported quality-of-life score, falls efficacy score, depression, pain interference with everyday activities, and life-space mobility score changed between baseline and follow-up. |
| 5. Determine whether client's mean number of home hazards changed between baseline and follow-up; frequency distribution of types of home modifications provided. |
| 6. Determine whether clients' mean number and cost of unplanned emergency department (ED) visits, overnight hospitalization visits, and rehab/skilled nursing facility stays changed between baseline and follow-up. |

In addition to the above objectives, the Contractor will collect sociodemographic data, such as household income, race/ethnicity, age, etc. Data on the length of time clients have lived in their home at baseline, and where and why some clients moved during the Evaluation period, will be compared with available national and regional data on homeowner relocations from the American Housing Survey (AHS). The Contractor will use AHS National and Metropolitan Public Use Files (PUF) microdata to identify the appropriate AHS populations (e.g., householders above a certain age who own their homes) for comparison with Evaluation clients' tenure.[29] Additionally, as part of the evaluation of client tenure, the Contractor will explore client concerns about aging-in-place (e.g., concerns about returning home after a medical event or needing to move out of their home). The analysis methods for these variables will be addressed in B.2.

### Overview of Data Collection Instruments

This evaluation will include up to 32 grantees that receive awards. Grantees participating in the Evaluation will be expected to collect data using the forms identified in Table 3. The Evaluation will collect data from clients of participating grantees. The OAHMP Evaluation will focus on the activities of the grantees and the impact of the grant program on clients. Under Section F. Program-Specific Requirements Affecting Eligibility of OLHCHH's OAHM Program NOFO, grantees must accommodate Limited English Proficiency (LEP) and Section 504 needs of any clients enrolled in the program. In addition to the Threshold Eligibility Requirements listed under

[28] Comparison of Evaluation data to Centers for Medicare and Medicaid services data is required under the PD&R solicitation for this Evaluation. U.S. Department of Housing and Urban Development. Amended 86614620Q00009 – FY20 Home Mod Study Solicitation, op. cit. Pages 10 and 13.
[29] U.S. Census Bureau. American Housing Survey 2019 Public Use File (PUF). Retrieved from: https://www.census.gov/programs-surveys/ahs/data/2019/ahs-2019-public-use-file--puf-.html.

III. Limited English Proficiency, OAHM Program grantees are required to take reasonable steps to ensure meaningful access to their program and activities for LEP individuals.

Grantee staff will collect data related to the Process Evaluation from all applicants (e.g., appendices B and if applicable, G) and all clients (e.g., appendices D, H, and if applicable, G). Consequently, for the most part, the Evaluation intends to rely on the grantees' own processes to address and meet clients' LEP needs and Section 504 services as grantee staff will be required to administer and complete Evaluation forms for OAHM Program clients.

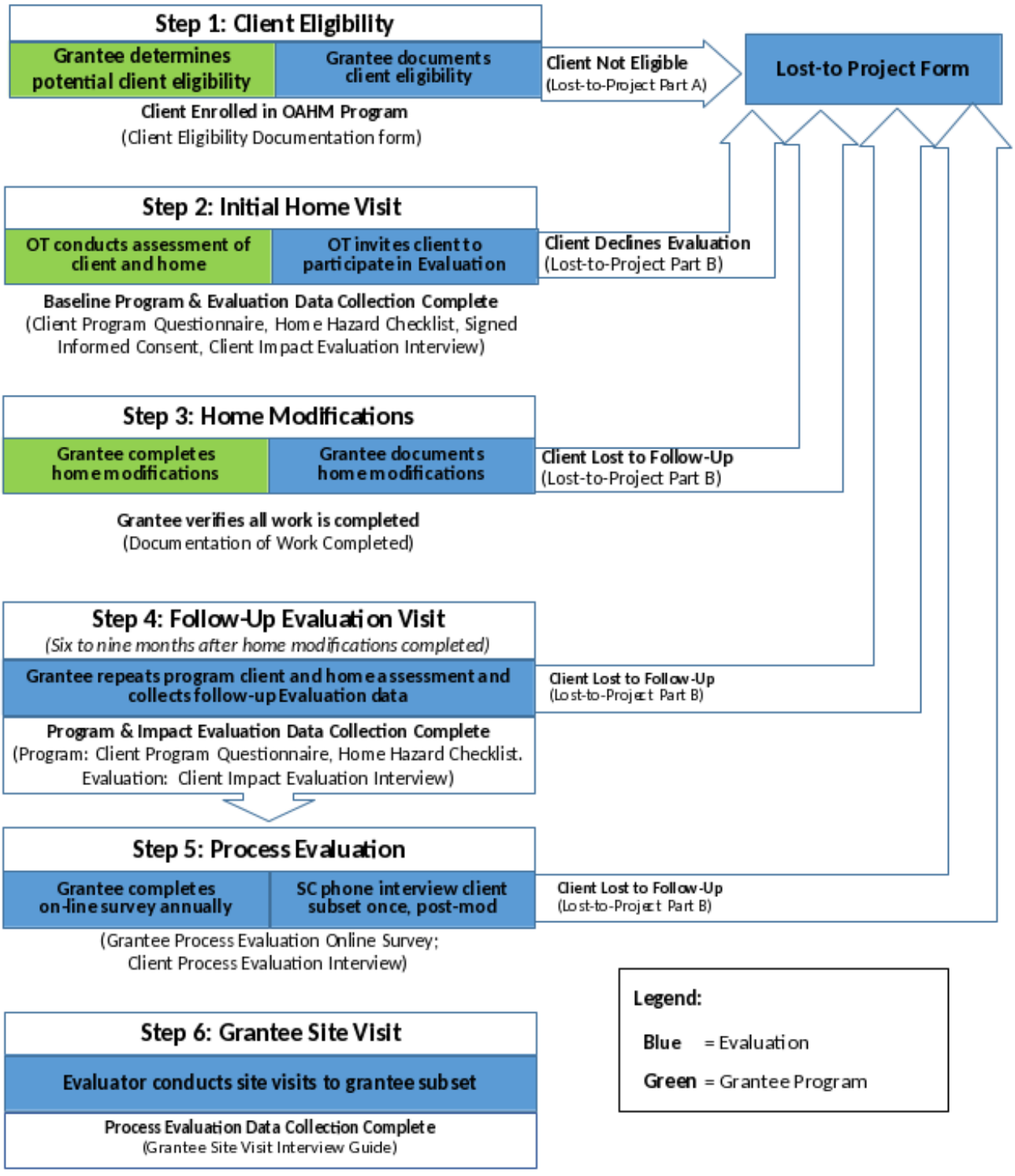
The Impact Evaluation requires direct responses from the clients (e.g., appendices C, E, F, K, and L). In order to be able to compare these responses to questions in the Centers for Medicare and Medicaid Services' Medicare Health Outcomes Survey (HOS)—a key objective (Table 2)—it is necessary for the wording of these questions to be exact. Grantees will be provided translations of these documents in both English and Spanish, which are the most prevalent first languages in the U.S.,[30] for use with their clients. Therefore, the Impact Evaluation will be confined to English- or Spanish-speaking clients. Given the possibility that grantees will provide services to clients with other language needs, we acknowledge this will be a limitation to the study's generalizability, but it is not cost-effective (given the scope of the Evaluation contract) to produce translations of these documents for all languages that clients may potentially speak. See B.1 for additional information regarding the selection of clients to participate in the Evaluation. Clients who do not participate in the Evaluation will still receive the full benefits and services of the OAHM Program.

The only data the Contractor will collect directly from clients will be during the Client Process Evaluation Interview which will be conducted virtually via phone or video. These calls will be conducted with a small subset (10%) of clients participating in the Impact Evaluation. If needed, the Contractor will make accommodations for clients with disabilities who are participating in the Impact Evaluation using TTY or other assistive technology. Additionally, as a reasonable accommodation for individuals with disabilities, the Contractor will conduct up to two interviews during the scheduled grantee site visits with clients who missed their Client Process Evaluation calls to allow data collection in person.

On the following pages, Figure 1 illustrates the workflow and Table 3 demonstrates the general content of all DCIs and administrative responsibilities. The flowchart identifies Evaluation forms grantees will complete at each stage of OAHMP implementation. For program purposes, grantees can choose to use either their own forms or Evaluation forms; however, if they choose to use their own forms, they must separately complete the Evaluation forms. The data collection forms the Contractor has developed for the Evaluation are consistent with the OLHCHH NOFO requirements for standardized assessment of program activities and client outcomes, and do not request information not pertinent to those requirements. Grantee program forms are not replacements for Evaluation forms. Post-modification forms are, for the most part, identical to the baseline forms.

[30] U.S. Census Bureau. American Community Survey: LANGUAGE SPOKEN AT HOME. TableID: S1601. https://data.census.gov/cedsci/table?q=language&tid=ACSST1Y2019.S1601. Accessed June 17, 2021.

**Figure 1. OAHM Program and Evaluation Work Flowchart**



| Table 3. Data Collection Instruments (DCIs) | | | | |
|---|---|---|---|---|
| **Form** | **Purpose** | **Process or Impact Objective(s) Addressed** | **Timing** | **Who Administers the DCIs** |
| **Client Eligibility Documentation Form** (appendix B) | Documents client eligibility by home ownership, condition of the home, income, and age. Also documents language spoken in the home. | Process #1, 2 | Before the baseline visit | Grantees for all potential clients and clients. |
| **OAHM Client Program Questionnaire, Baseline** (appendix C, includes Baseline and Post-modification surveys, English and Spanish versions) | Collects data on ADLs, IADLs, and falls. Questions are needed to assess client health and physical function status before home modification. (A discussion of the validated questionnaires included in this instrument appears in A.7, Table 5.) | Impact #1, 3 | Baseline | Grantees to all clients. |
| **Home Hazard Checklist, Baseline** (appendix D, includes Baseline and Post-modification checklists) | Collects data on housing characteristics and conditions to help grantee identify needed home modifications. Home hazard data will also be used to compare the number of home hazards before and after home modifications. | Process #2<br>Impact #5 | Baseline | Grantees for all clients. |
| **OAHM Program Evaluation Informed Consent** (appendix E, English and Spanish versions) | Embedded in the OAHM Impact Evaluation Interview to have grantees obtain consent to ask for Evaluation data (i.e., demographic information, health and physical function, unplanned healthcare utilization, and other conditions). | Not applicable | Baseline | Grantees to all clients. Informed consent form is signed by the client and witnessed and signed by grantee representative. |
| **OAHM Client Impact Evaluation Interview, Baseline** (appendix F, includes Baseline and Post-modification survey, English and Spanish versions) | Collects demographic data, health conditions, and unplanned healthcare usage, including responses to standardized scales on quality of life (EuroQOL), falls efficacy (Tinettis Falls Scale), movement within and outside the house within the past four weeks (University of Alabama at Birmingham Aging Life Space Assessment), depression (The Patient Health Questionnaire PHQ-9), and Medicare Health Outcomes Survey (HOS) questions on ADLs and IADLs. Inclusion of Medicare HOS ADL and IADL questions will enable | Impact #1-4, 6 | Baseline | Grantees to all clients who signed the Informed Consent |

| Table 3. Data Collection Instruments (DCIs) | | | | |
|---|---|---|---|---|
| **Form** | **Purpose** | **Process or Impact Objective(s) Addressed** | **Timing** | **Who Administers the DCIs** |
| | the Evaluation to compare client data to regional and national trend data. For unplanned healthcare usage data, Agency for Healthcare Research and Quality (AHRQ) MEPS data[31] will be used to assign regional costs to clients' emergency response calls, ED visits, and unplanned hospitalizations. (Citations and discussion of the validated questionnaires included in this instrument appear in A.7, Table 5.) | | | |
| **Lost-to-Project Form** (appendix G) | Tracks program decisions not to enroll a client in the program and documents the reasons for a client being de-enrolled from the program after enrollment | Process #2 | Once for each ineligible potential client or each enrolled client lost to follow-up. | Grantees for each ineligible potential client and each enrolled client lost to follow-up. |
| **OAHM Program Documentation of Work Completed Form** (appendix H) | Identifies type and room location of completed work, whether additional funds from other programs were used to cover modification costs, and costs for grantee in-house labor, subcontractor labor, and materials. | Process #2, 3, 7<br>Impact #5 | Once, within approximately one month of completing home modifications. | Grantees for all clients who received home modifications. |
| **OAHM Client Program Questionnaire, Post-modification** | Collects data on ADL, IADL, and falls to identify changes in health outcomes between baseline and post-home modification using the same questions as in the OAHM Client Program Questionnaire Baseline Form. | Impact #1, 3 | 6 to 9 months post-home modifications. | Grantees to clients who received home modifications and signed informed consents. |
| **OAHM Client Impact Evaluation Interview, Post-modification** | Collects post-home modification data using the same questions as in the OAHM Client Impact Evaluation Interview Baseline form. | Impact #1-4, 6 | 6 to 9 months post-home modifications. | Grantees to clients who received home modifications and signed informed |

[31] Agency for Healthcare Research and Quality). 2017. Most recent Codebook definition accessed from Medical Expenditure Panel Survey (MEPS), household component. Sample restricted to (IPTEXP17): "Age 65+ with Total Hospital Inpatient Facility and Doctor Expenses greater than zero" subtracting average inpatient expenditures with zero nights. Weighted estimates obtained using MEPSnet/Household Component. https://meps.ahrq.gov/mepsweb/data_stats/download_data_files_codebook.jsp?PUFId=H201&varName=IPTEXP17. Accessed June 17, 2021.

| Table 3. Data Collection Instruments (DCIs) | | | | |
|---|---|---|---|---|
| **Form** | **Purpose** | **Process or Impact Objective(s) Addressed** | **Timing** | **Who Administers the DCIs** |
| | | | | consents. |
| **Home Hazard Checklist, Post-modification** | Collects data to compare the number of home hazards at baseline and after home modifications are completed using the same questions as in the Home Hazard Checklist Baseline Form. | Process #2<br>Impact #5 | 6 to 9 months post-home modification. | Grantees to clients who received home modifications and signed informed consents. |
| **Grantee Process Evaluation Online Survey Year 1**<br>(appendix I includes survey for Years 1, 2, and 3) | Reviews grantee's reasons for applying for OAHMP grant, experience with recruitment, enrollment, factors considered in developing the scope of work for home modifications. Summarizes approaches to targeting locations for program services, progress in enrollment and home modifications completed for the year. Provides data on strategies, successes, and challenges in meeting grantee and OAHMP goals over the first year of program implementation. | Process #3-5, 6, 8 | Once for each grantee, near the end of Year 1 of the OAHMP. | Program Manager from each of up to 32 grantees completes survey. Contractor Site Coordinators (SCs) monitor online survey completion. |
| **Grantee Process Evaluation Online Survey Year 2** | Summarizes any changes from the grantees' initial service model or target locations from those reported in Year 1. Summarizes progress in enrollment and home modifications completed for the year. Provides data on strategies, successes, and challenges in meeting grantee and OAHMP goals over the second year of program implementation. | Process #3-5, 6, 8 | Once for each grantee, near the end of Year 2 of the OAHMP. | Program Manager from each of up to 32 grantees completes the online survey. Contractor SCs monitor online survey completion. |
| **Grantee Process Evaluation Online Survey Year 3** | Summarizes any changes from the grantees' initial service model or target locations from those reported in Year 2. Summarizes progress in enrollment and home modifications completed for the year. Provides data on strategies, successes, and challenges in meeting grantee and OAHMP goals over the third year of program implementation. | Process #3-5, 6, 8 | Once for each grantee, near the end of Year 3 of the OAHMP. | Program Manager from each of up to 32 grantees completes the online survey. Contractor SCs monitor online survey completion. |

| Table 3. Data Collection Instruments (DCIs) | | | | |
|---|---|---|---|---|
| **Form** | **Purpose** | **Process or Impact Objective(s) Addressed** | **Timing** | **Who Administers the DCIs** |
| **Grantee Site Visit Interview Guide** (appendix J) | Provides guide for discussion of grantee experiences. | Process #3-5, 6, 8 | Once, during site visits to each of up to 16 grantee offices Site visits will occur over a three-year period. | Contractor Project Manager interviews up to two grantee representatives from each of up to 16 grantees. |
| **Script to Schedule Client Process Evaluation Interview** (appendix K, English and Spanish versions) | Helps SC work with clients to set the date, time, and preferred method of administering the Interview | Process #9 | Once, within 6-9 months post-modification. | Contractor SCs schedule interviews for up to 10% of clients who received services via the OAHMP. |
| **Client Process Evaluation Interview** (appendix L**,** English and Spanish versions) | Allows clients to discuss their experiences with program recruitment, decision to apply for the program, interactions with OAHMP grantee staff, satisfaction with the work completed, and perceived benefits of the modifications. | Process #9 | Once, within 6-9 months post-modification. | Contractor SCs conduct interviews and enter data for 10% of clients who received services by the grantees, up to approximately 500 respondents. |

Where appropriate, the Contractor will compare certain Evaluation data on ADLs and IADLs with available national and regional data from the Medicare HOS. To facilitate these comparisons, questions in the OAHM Client Impact Evaluation Interview (baseline and post-modification) use language from these sources. For unplanned healthcare usage data, the Contractor will use regional Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey (MEPS) data[32] to assign costs to clients' emergency response calls, ED visits, and unplanned overnight hospitalizations. Specific questions or variables from these sources are covered in more depth in A.7, Table 5. Additional details on statistical approaches and procedures for analyzing these data are provided in B.2.

### Staff Qualifications and Training

*OAHM Grantees*

Grantees participating in the Evaluation will have multiple staff assigned to their program's operations; these may include project managers, clerical staff, construction managers, licensed OTs, licensed OTAs, CAPS, registered nurses, social workers, in-house repair staff, and construction subcontractors. Grantees determine the qualifications for their staff. Grantee staff will be responsible for recruitment and enrollment of older adult's homes into the OAHMP, verification of client eligibility, primary contact with the resident/client, design and management

[32] Ibid.

of home modifications, oversight to ensure OAHMP work is completed appropriately, and administration of all the Evaluation forms identified as grantee responsibilities in Table 3 according to the specified timeframes. Grantees are responsible for determining and documenting the methods they will use to address LEP and Section 504 requirements for clients (see appendix B). Grantees will be expected for the purposes of this Evaluation to use those same procedures for administering Evaluation forms.

The Contractor will utilize Vanderbilt University's Research Electronic Data Capture (REDCap)[33,34,35] system for Evaluation data collection and storage and provide grantees access to the REDCap platform to complete Evaluation DCIs)for which they are responsible. REDCap is a secure, web-based, HIPAA-compliant environment for building and managing web-based, non-commercial projects. Table 4 identifies who will administer specific DCIs (i.e., grantees or the Contractor's Site Coordinators) and input the data into REDCap. As grantees will be required to collect and enter Evaluation data into REDCap, the Contractor will provide training on use of REDCap and administration of the DCIs. Specifically, the Contractor's Senior Research Associate (SRA) or designee will train grantee-designated management and data entry staff on:

- Evaluation schedule and how it aligns with the OAHMP grant's deliverables schedule;
- Protocols requesting potential clients' participation in the Evaluation (Informed Consent);
- Evaluation data collection protocols and instruments; and
- REDCap data entry procedures and tools.

Training sessions will occur via four half-day (i.e., four-hour) webinars with up to eight grantees each. The Contractor will record at least one of the training webinars and make the recording available to grantees for new staff and self-guided refresher training purposes, as needed.

*Contractor Site Coordinators*

To facilitate interactions with grantees and to monitor progress in completing the DCIs described in Table 3, the Contractor will employ Site Coordinators (SCs) who will be responsible for working with a specified number of OAHMP grantees, assigned based on the regional distribution of the grantees. SC responsibilities will include:

- Monitoring monthly, at a minimum, grantees' completion of DCIs and engaging in quality control reviews of the data entered by the grantees.
- Monitoring completion of the annual Grantee Process Evaluation Survey in REDCap, including a review of information and contacting grantee representatives by phone or email to assure data entry is complete.

[33] Harris, Paul A., Robert Thielke, Jonathan Payne, Nathaniel Gonzalez, and Jose G. Conde. 2009, April. "Research electronic data capture (REDCap) – A metadata-driven methodology and workflow process for providing translational research informatics support," *Journal of Biomedical Informatics* 42(2):377-81. doi: 10.1016/j.jbi.2008.08.010.
[34] Harris, Paul A., Robert Taylor, Brenda L Minor, Veida Elliott, Michelle Fernandez, Lindsay O'Neal, Laura McLeod, Giovanni Delacqua, Francesco Delacqua, Jacqueline Kirby, Stephany N Duda,and REDCap Consortium. 2019, May. "The REDCap consortium: Building an international community of software partners," *Journal of Biomedical Informatics* 95:103208. doi: 10.1016/j.jbi.2019.103208.
[35] Vanderbilt University. REDCap Technical Overview. Retrieved at https://projectredcap.org/wp-content/resources/REDCapTechnicalOverview.pdf

- Monitoring optional grantee group conversations in REDCap "Messenger," a REDCap function which will serve as a central location for grantee and Contractor staff to communicate securely. SCs will alert the SRA if there is a need to correct or provide guidance as questions arise concerning Evaluation protocols.
- Hosting, with other Contractor team members, up to eight optional peer-to-peer webinars during the OAHMP grant's period of performance. These webinars will provide grantees a forum to learn from each other and share lessons learned, barriers, successes, and other information. (Grantees may, of course, learn and share among themselves outside of the webinars.) Grantees will be notified in advance that sessions will be recorded. SCs will use these recordings (and notes taken during the sessions) to summarize results of the webinars (without identifying specific grantee organizations or grantee survey respondents) for review when the Contractor writes the Evaluation's annual and final reports. Recordings will be stored on the Contractor's Cloud Server (currently Microsoft 365 SharePoint), which is password-protected. Recordings will be deleted once HUD has approved the final Evaluation reports.
- Administering the Client Process Evaluation Interview to a sample of up to 10% of the grantees' clients (i.e., approximately 500 clients) six- to nine-months after home modifications have been completed.

Participating in site visits at up to 16 OAHMP grantee sites over the OAHMP grant period of performance. Each SC will accompany the Contractor's Project Manager (PM) to site visits to the SC's assigned grantees. During these scheduled grantee site visits, SCs will accompany grantee staff on one or two client home visits per to evaluate grantee protocols when working with OAHMP clients. If feasible, SCs will ask the grantee to conduct home visits with clients who missed the SC's Client Process Evaluation Interview call or who have disabilities to allow data collection in person. SCs will be fluent in English and Spanish, which are the most prevalent first languages in the U.S.,[36] to enable them to conduct the Client Process Evaluation Interviews in one of those two languages as needed. They will have strong communication skills and previous interviewing or public contact experience (phone and in-person). Before hiring, the Contractor will obtain references and verify work history for all potential SCs. The Contractor will perform background checks to ensure prospective SCs have no criminal records. SCs will be managed on a day-to-day basis by the Contractor's PM.

The Contractor's SRA and PM, or their designees, will train SCs and other Contractor team members via webinar on:

- The Evaluation schedule;
- Evaluation data collection protocols and instruments;
- REDCap Process Evaluation data entry procedures;
- How to present the Client Process Evaluation Interview (appendix L) to clients in a gently convincing, supportive manner. This training will include refusal conversion strategies the SCs may use to gain client participation after a client's initial refusal (these procedures are discussed in more detail in B.3); and

[36] U.S. Census Bureau. American Community Survey: LANGUAGE SPOKEN AT HOME. TableID: S1601. https://data.census.gov/cedsci/table?q=language&tid=ACSST1Y2019.S1601. Accessed June 17, 2021.

- How to run REDCap reports developed by the Contractor's Biostatistician to monitor accuracy and timing of grantees' data collection according to the Evaluation schedule, including monthly quality control checks on grantees' progress on:
    - Clients for whom the Client Eligibility Documentation form has been completed, listing clients found eligible and those found ineligible for the OAHMP;
    - Clients for whom the first Evaluation in-home visits have been completed (i.e., the baseline OAHM Client Program Questionnaire, Home Hazard Checklist, and OAHM Client Impact Evaluation Interview). This report will include a list of clients who signed the informed consent and those who declined to sign the informed consent, based on their responses to Question A.1 in the OAHM Client Impact Evaluation Interview forms;
    - Homes with documented home modifications (i.e., those with Documentation of Work Completed forms);
    - Clients for whom the follow-up Evaluation in-home visits have been completed (i.e., the follow-up OAHM Client Program Questionnaire, Home Hazard Checklist, and OAHM Client Impact Evaluation Interview); and
    - Clients and homes lost to follow-up (with completed Lost-to-Project forms).

The training webinar will be recorded and made available to SCs and other members of the Contractor's team for self-guided refresher training purposes, as needed.

## 3. Use of Information Technology to Reduce Burden

*Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration of using information technology to reduce burden.*

HUD has determined alternative means of data collection, such as by telephone or Internet, are feasible for many of the DCIs submitted under this ICR. The Contractor will use REDCap, a secure HIPAA-compliant computer-assisted data collection system, to collect data for computer-assisted personal interviewing (CAPI) or computer-assisted telephone interviewing (CATI) purposes as specified in Table 3. Computer-assisted data collection reduces grantees' burden by minimizing the time and costs associated with reproducing, administering, and storing paper-based DCIs, or with later data entry of data from paper-based forms into other platforms, which grantees would then have to post to other secure sites. The Contractor will remove Personally Identifying Information (PII) from the collected data before submitting it to HUD. Additionally, as the Contractor will not use a HUD system to collect this data, it was determined no Privacy Impact Assessment is required.

Grantees will have access to REDCap at no expense to them. The REDCap Technical Overview provides more detail on the security of the overall REDCap system.[37]

[37] Vanderbilt University. Technical Overview, op cit.

The Contractor's programming of the REDCap OAHMP Evaluation project platform includes features allowing (1) upload of hard-copy scans; (2) identification and correction of data entry issues in real time through logic and completion rules; and (3) timely review and correction of missing, inconsistent, out of range, or improbable data. The Contractor's Biostatistician will use a password-protected, secure network to access Evaluation data.

The Contractor's Biostatistician and SRA will set up a REDCap permission framework to help maintain data confidentiality by ensuring people can access only those forms and data they need as part of their work. For example, grantees will have access to data from their grantee site but will not have access to other grantees' data. Another example, to protect clients' privacy, grantees will not be granted access to data from the Client Process Evaluation Interview.

Table 4 identifies the data collection method and data entry method for each DCI in the Evaluation.

**Table 4. Data Collection Method and Data Entry Method**

| Form | Administered via | Data entry and storage method |
|---|---|---|
| Client Eligibility Documentation | Documentation by grantee | Programmed in REDCap |
| Lost-to-Project | Completed online by grantee after determination of client's ineligibility and if enrolled client is lost to follow up | Programmed in REDCap |
| OAHM Program Evaluation Informed Consent | In-home interview by grantee | Scanned copy of signed form uploaded to REDCap |
| OAHM Client Program Questionnaire (Baseline and Post Modification) | In-home interview by grantee | Programmed in REDCap |
| OAHM Client Impact Evaluation Interview (Baseline and Post-modification) | In-home interview by grantee | Programmed in REDCap |
| Home Hazard Checklist (Baseline and Post-Modification) | In-home observation grantee | Programmed in REDCap |
| OAHM Program Documentation of Work Completed | Completed in Excel by grantee after in-person visit | Programmed in Excel, completed Excel spreadsheet uploaded to REDCap |
| Grantee Process Evaluation Online Survey Years 1, 2, and 3 | Completed online by grantee | Programmed in REDCap |
| Grantee Site Visit Interview Guide | In-person by the Contractor's PM and/or SC | Scanned copy of notes uploaded to REDCap |
| Script to Schedule Client Process Evaluation Interview | By phone or video by the Contractor's SCs | Programmed in REDCap |
| Client Process Evaluation Interview | By phone or video by the Contractor's SCs | Programmed in REDCap |

## 4. Efforts to Identify Duplication

*Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.*

The OAHMP is a new program for which no previous administrative data have been collected. In addition to a general need to better understand what home modifications could result in cost savings to Medicare, Medicaid, or other insurance providers, HUD needs data to evaluate the effectiveness of this new program itself (e.g., Does it achieve its goals? Can its administration be improved?). HUD needs data that can be generalized to support national or regional applications for this type of grant program, including a better understanding of the impact of a diverse set of program administrative structures and capacities, geographies, and clients, and an assessment of the healthcare cost savings associated with home modifications provided under the OAHMP.

To compare OAHMP outcomes to national and regional data, the OAHM Program Questionnaire and OAHM Client Impact Evaluation Interview will incorporate questions from the U.S. Centers for Medicaid and Medicare Services (CMS) Health Outcomes Survey (HOS), the National Health Information Survey, and other validated surveys. These surveys are discussed in A.7.

The OAHMP Evaluation design strategy was reviewed by the following individuals to assure lack of duplication with other surveys:

| **Name** | **Affiliation** |
|---|---|
| Jagruti D. Rekhi, MS | HUD/Office of Policy Development and Research |
| Mark D. Shroder, PhD | HUD/Office of Policy Development and Research |
| Regina C. Gray, PhD | HUD/Office of Policy Development and Research |
| Patricia Schwindinger, MA | HUD/Office of Policy Development and Research |
| | |
| Warren Friedman, PhD | HUD/Office of Lead Hazard Control and Healthy Homes |
| Peter Ashley, DrPH | HUD/Office of Lead Hazard Control and Healthy Homes |
| Yolanda Brown | HUD/Office of Lead Hazard Control and Healthy Homes |
| | |
| Amanda Reddy, MS | Healthy Housing Solutions, Inc. (HUD's designated Contractor) |
| Noreen Beatley, MPA | Healthy Housing Solutions, Inc. |
| Michael Eriksen, PhD | Healthy Housing Solutions, Inc. |
| Carolyn Kawecki, MA | Healthy Housing Solutions, Inc. |
| | |
| Jonathan Wilson, MPP | National Center for Healthy Housing (Solutions' subcontractor) |
| Jill Breysse, MHS, CIH | National Center for Healthy Housing |
| Sherry Dixon, PhD | National Center for Healthy Housing |

## 5. Impact on Small Businesses

*If the collection of information impacts small business or other small entities (Item 5 of OMB Form 83-I), describe any methods used to minimize burden.*

Information collection will not be burdensome for small businesses.

## 6. Policy Implications if Information is Not Collected

*Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.*

The purpose of this Evaluation is to expand the evidence base for HUD funding for future grant programs to improve housing for low-income older adults. If this information is not collected, progress making U.S. housing stock healthy and safe for owner-occupant older adults will not be based on the current information on units with significant housing-related safety and health hazards for this population.

## 7. Special Circumstances

*Explain any special circumstances that would cause an information collection to be conducted in a manner:*

- *Requiring respondents to report information to the agency more often than quarterly;*

  Not applicable

- *Requiring respondents to prepare a written response to a collection of information in fewer than 32 days after receipt of it;*

  OLHCHH will specify grantees have 32 days (or the next federal business day following) to respond to HUD.

- *Requiring respondents to submit more than an original and two copies of any document;*

  Not applicable

- *Requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records, for more than three years;*

  Not applicable

- *In connection with a statistical survey, that is not designed to produce valid and reliable results than can be generalized to the universe of study;*

  Not applicable. This project will evaluate program processes and outcomes and is not a statistical survey. As appropriate for the Evaluation's purposes, the DCIs incorporate survey questions and scales that have demonstrated valid and reliable results.

| Table 5. Standardized Data Collection Instruments (DCIs) | | | |
|---|---|---|---|
| **Topic** | **Description of Measure and Its Purpose** | **Question Format** | **Questions as they appear in DCIs** |
| Demographic information and expected tenure in the home | Identifies gender, ethnic and racial identify, educational status, plans for movement to another community, importance of remaining in the home for as long as possible, self-assessment of whether the home is accessible for special needs or disabilities. | Some demographic questions come from the CMS Medicare HOS questionnaire (HOS 3.0 2020).<br><br>Tenure questions from 2020 AARP Age-Friendly Community Survey. | OAHM Client Impact Evaluation Interview Form, Section B |
| ADL and IADL difficulty scores | Measures residents' difficulty, if any, in performing one or more of eight ADLs and eight IADLs with high test–retest reliability and sensitivity.[38, 39, 40] Provides consistency in assessment of ADLs and IADLs across grantees.<br><br>Compares client ADL and IADL data with CMS Medicare HOS cohort data filtered by U.S. region and income to match Evaluation populations. | No Changes to Katz et al. and Gill et al. for ADL questions.<br><br>No Changes to Lawton and Brody for IADL questions.<br><br>No Changes to Medicaid 2020 HOS ADL and IADL questions. | OAHM Client Program Questionnaire Form Sections A, B<br><br>OAHM Client Impact Evaluation Interview Form, Sections G, H |
| Quality of life | Measures health-related quality of life using a EuroQol questionnaire (EQ-5D)[41] asking clients to report on problems with five "dimensions": walking, self-care, usual activities, pain, or anxiety/ depression and general health self-ratings on a visual analog scale (VAS). | No changes to EuroQol questionnaire (EQ-5D). | OAHM Client Impact Evaluation Interview Form Section D |
| Falls efficacy | Measures changes in client's anxieties about falling during specific home activities using the Tinetti Falls Efficacy Scale,[42] which has strong relationship to function, mediates fall prevention improvement, and has strong reliability and validity. | No changes to Tinetti Falls Efficacy Scale. | OAHM Client Program Questionnaire Form Section C |

[38] Gill, Thomas M., Dorothy I. Baker, Margaret Gottschalk, Peter N. Peduzzi, Heather Allore, and Amy Byers. 2002, October. "A program to prevent functional decline in physically frail, elderly persons who live at home," *New England Journal of Medicine* 347(14):1068-1074. doi: 10.1056/NEJMoa020423.

[39] Katz, Sydney, Amasa Ford, Roland W. Moskowitz, Beverly A. Jackson, and Marjorie W. Jafee. 1963, September. "Studies of illness in the aged. The index of ADL: A standardized measure of biological and psychosocial function," *JAMA* 185(12):914-919. doi: 10.1001/jama.1963.03060120024016.

[40] Lawton, M.P. and E.M. Brody. 1969, Autumn. "Assessment of older people: self-maintaining and instrumental activities of daily living," Gerontologist 9(3):179-186. PMID: 5349366.

[41] Euro QOL 1998. EQ-5D-3L Health Questionnaire English Version for the USA. © 1998 EuroQOL Group EQ-5DTM is a trademark of the EuroQOL Group.

[42] Tinetti, M.E., D. Richman and L. Powell. 1990, November. "Falls efficacy as a measure of fear of falling," *Journal of Gerontology* 45(6):239-243. doi: 10.1093/geronj/45.6.p239.

| Table 5. Standardized Data Collection Instruments (DCIs) | | | |
|---|---|---|---|
| **Topic** | **Description of Measure and Its Purpose** | **Question Format** | **Questions as they appear in DCIs** |
| Mobility in and outside homes | University of Alabama at Birmingham's Life-Space Assessment is a validated tool to measure changes in person's independence and spatial mobility (can range from limited to sleeping area [e.g., bedroom] to independent travel out of town).[43] | No changes to Birmingham's Life-Space Assessment. | OAHM Client Impact Evaluation Interview Form Section E |
| Number and causes of in-home falls | Questions from validated CDC National Health Interview Survey (NHIS) to compare rates to regional and national data. | Modification to 2008 National Health Information Survey Adult Balance and Dizziness.<br><br>The Evaluation also created its own questions related to falls.<br><br>Number of times fell: Behavioral Risk Factor Survey 2014. | OAHM Program Questionnaire Form Section D |
| Unplanned, home-related healthcare visit data | Uses Agency for Healthcare Research and Quality (AHRQ) MEPS data[44] to assign regional costs to clients' ED calls and visits and unplanned hospitalizations and to compare baseline versus six- to nine-month post-modification medical costs. | The evaluation created its own questions.<br><br>Modifications to MEPS Events Enumeration module. | OAHM Client Impact Evaluation Interview Form Section C |
| Depression | Records client's level of depression as a possible confounding factor associated with increased risk of falls.[45] | No changes to The Patient Health Questionnaire (PHQ-9) | OAHM Client Impact Interview (Baseline/ Post-modification) Section H |
| Client home tenure data | Collects data on length of time recipient lived in home and reasons why and where some clients moved during evaluation period to compare with national and regional AHS data on older adult relocations. Solutions will use AHS National and Metropolitan Public Use Files (PUF) microdata to identify appropriate AHS populations (e.g., homeowners above a certain age) to compare with Evaluation clients' tenure.[46] | | Lost-to-Project Form Section B<br><br>OAHM Client Impact Evaluation Interview Form (Baseline), Section B<br><br>Client Process Evaluation Interview Form, Questions 2 and 3 |

[43]Peel, Claire, Patricia Sawyer Baker, David L. Roth, Cynthia J. Brown, Eric V. Brodner, and Richard M Allman 2005, October. "Assessing mobility in older adults: The UAB study of Aging Life-Space Assessment," *Physical Therapy* 85(10):1008-1019. PMID: 16180950.

[44] Agency for Healthcare Research and Quality, op. cit.

[45] Kroenke, Kurt, Robert L. Spitzer, and Janet B.W. Williams. 2001, September. The PHQ-9: Validity of a brief depression severity measure," *Journal of General Internal Medicine* 16(9):606-613. doi: 10.1046/j.1525-1497.2001.016009606.x.

| Table 5. Standardized Data Collection Instruments (DCIs) | | | |
|---|---|---|---|
| **Topic** | **Description of Measure and Its Purpose** | **Question Format** | **Questions as they appear in DCIs** |
| | Will explore concerns about aging in place (e.g., anxieties about returning home after medical event or needing to move out of home). | | |
| Home hazard data | Assesses housing hazards with checklist adapted from<br>• CDC's 2015 brochure, *Check for Safety: A Home Fall Prevention Checklist for Older Adults;*<br>• CPSC's *Safety for Older Consumers - Home Safety Checklist;*<br>• PD&R's *Accessibility of America's Housing Stock: Analysis of the 2011 AHS;*<br>• Rebuilding Together's *Safe at Home Checklist;* and<br>• HUD NOFO appendix B, *"Home Modifications/Repairs."* | Modifications to Check for Safety: A Home Fall Prevention Checklist for Older Adults<br>CPSC's Safety for Older Consumers – Home Safety<br>Accessibility of America's Housing Stock: Analysis of the 2011 American Housing Survey<br>Safe at Home Checklist | Home Hazard Checklist Form |

- *Requiring the use of a statistical data classification that has not been reviewed and approved by OMB;*

  Not applicable

- *That includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use;*

  Not applicable (see A. 10).

- *Requiring respondents to submit proprietary trade secrets, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

  Not applicable.

[46] U.S. Census Bureau. American Housing Survey, op cit.

## 8. Summary of Consultations and Comments Received

*If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.*

The text of the PD&R 60-day notice is under final review. A summary of comments will be provided in later drafts of this ICR.

*Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and record-keeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.*

HUD continues to consult with the following private sector experts to assure the project meets federal needs and avoids duplication.

| | |
|---|---|
| Amanda Reddy | Healthy Housing Solutions, Inc. |
| Carolyn Kawecki | Healthy Housing Solutions, Inc. |
| Noreen Beatley | Healthy Housing Solutions, Inc. |
| Michael Eriksen | Healthy Housing Solutions, Inc. |
| Jonathan Wilson | National Center for Healthy Housing |
| Jill Breysse | National Center for Healthy Housing |
| Sherry Dixon | National Center for Healthy Housing |

*Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years - even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.*

Not applicable. The Grantee Process Online Evaluation Survey is administered annually to OAHMP grantees, providing the opportunity to communicate any concerns about the Evaluation data collection. Should grantees have questions about specific items in the survey, they can speak with the Contractor's PM or SCs. If they have concerns about the Evaluation as a whole or the Contractor, they should contact Ms. Jagruti Rehki, Contract Office Representative, PD&R.

## 9. Incentives for Respondents

*Explain any decision to provide any payment or gift to respondents, other than remuneration to contractors or grantees.*

Grantee respondents receive no remuneration to participate in the Evaluation. Participation is required under the OLHCHH NOFO: "Grantees must cooperate fully with any research or evaluation sponsored by HUD or another government agency associated with this grant program, including preservation of project data and records and compiling requested information in formats provided by the researchers, evaluators or HUD. This may include the compiling of certain

relevant local demographic, dwelling unit, and participant data not contemplated in the original proposal."[47]

HUD does not intend to provide any gift or incentive to client respondents to participate in the Evaluation.

## 10. Confidentiality of Information

*Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.*

Each grantee client will be assigned a numeric site identification (Site ID) which will mask their personal information. Additionally, the assurance of privacy given to respondents in the OAHM Program Evaluation Informed Consent (see appendix E) is consistent with U.S. Department of Health and Human Services (HHS) policy regarding HIPAA protections for medical data,[48] 12 USC §1701z–1[49] and 1701z–2(g)[50] for HUD's authority to collect the data and allowed uses for it, and 5 USC §552a[51] for the confidentiality and storage of de-identified data. Regulatory provisions guiding the nature and extent of confidentiality are found in 5 CFR 1320.9 and related provisions of 5 CFR 1320.8(b) (3)[52]. Respondents are assured data they provide will be kept private to the extent the law allows. HUD will use this information only for statistical research and reports. Participants are further informed that their answers will be combined with others, ensuring no one can identify which answers are specifically theirs. In addition, PD&R policy requires protection of the dignity, rights, safety and privacy of participants in all of its evaluations, particularly those pertaining to HUD-assisted households and HUD-insured borrowers through the Rule of Eleven. Although there is no assurance of confidentiality, under the Rule of Eleven, no disclosure of information about the characteristics of any group of individuals or households numbering less than eleven is allowed by PD&R staff, contractors, grantees, or licensees.[53] (See A. 11 for further description of the consent process).

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[47] U.S. Department of Housing and Urban Development. Office of Lead Hazard Control and Healthy Homes. Older Adults Home Modification Program, op. cit. Page 21.

[48] U.S. Department of Health and Human Services, Office for Civil Rights. 2013, March 26. HIPAA Administrative Simplification. Part 164, Subpart C Security standards for the Protection of Electronic Protected Health Information, p.62. Retrieved from: https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/combined/hipaa-simplification-201303.pdf?language=es

[49] U.S. Code at 12 U.S.C. §1701z-1, op cit.

[50] U.S. Code at 12 U.S.C. §1701z-2(g). https://uscode.house.gov/view.xhtml?req=(title:12%20section:1701z-1%20edition:prelim)

[51] U.S. Code at 5 U.S.C. §552a. https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title5-section552a&num=0&edition=prelim

[52] 5 CFR 1320.8(b) (3) and 5 CFR 1320.9. Retrieved from: https://www.govregs.com/regulations/expand/title5_chapterIII_part1320_section1320.9#regulation_7

[53] "PD&R-sponsored evaluations must be conducted in an ethical manner and safeguard the dignity, rights, safety, and privacy of participants. PD&R-sponsored evaluations must comply with both the spirit and the letter of relevant requirements such as regulations governing research involving human subjects. In particular, PD&R protects the privacy of HUD-assisted households HUD-insured borrowers through the Rule of Eleven; that is, PD&R allows no disclosure of information about the characteristics of any group of individuals or households numbering less than eleven by PD&R staff, contractors, grantees, or licensees." PD&R's HUD Program Evaluation Policy-Policy Statement (81 FR 87949, December 6, 2016, www.federalregister.gov/d/2016-29215).

## 11. Questions of a Sensitive Nature

*Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.*

Some questions in the OAHM Client Program Questionnaire (appendix C) and the OAHM Client Impact Evaluation Interview (appendix F) concerning health and health care utilization could be considered sensitive; however, they are necessary to confirm grantees are taking health conditions, particularly limitations in ADLs and IADLs, into account when identifying home modifications to address the client's needs. The CAPABLE program model, which is a basis for the OAHMP Service Model,[54] has been demonstrated to improve clients' functionality when an OT evaluated functional disability, identified and addressed functional goals, assessed home safety risks, and oversaw communication with the primary practitioner. Assessment of clients' pain, depressive symptoms, medication use, strength, and balance were also important since these factors can impair functionality and therefore mask the impact of the home modifications.

Questions in DCIs concerning quality of life; falls efficacy; mobility in and outside the home; number and causes of in-home falls; unplanned, home-related healthcare visit data; and client home tenure data are also necessary to enable HUD to compare clients' health outcomes pre-modification to post-modification and, where appropriate, to national and regional data.

Before administering the OAHM Client Impact Evaluation Interview questions, clients will be asked to complete an OAHM Program Evaluation Informed Consent that specifies:

- They do not have to participate in the Evaluation;
- Their responses to Evaluation questions are voluntary and will not affect their ability to receive home modifications if they are eligible for the program; and they can stop participating in the Evaluation at any time;
- They do not need to answer any question they are not comfortable answering;
- There is no cost to them to participate in the Evaluation;
- Evaluation documents with their name, address, or other personal identifying information will be handled with special care to protect privacy and all personal data will be replaced with a Site Identification Code (Site ID); and
- An acknowledgement that some documents containing information that may identify them may be shared with authorized users, but access to their individual responses will be limited. Authorized users include representatives of Healthy Housing Solutions and their subcontractor.

In addition, grantee and Contractor interviewers will be trained to be sensitive to any discomfort on the part of the respondent and to skip to the next question if they see the respondent is reluctant to answer the question. Training is discussed in more detail in B.2 and B.3.

[54] U.S. Department of Housing and Urban Development. Office of Lead Hazard Control and Healthy Homes. Older Adults Home Modification Program, op. cit. Page 5.

## 12. Estimated Time and Cost to Respondents

*Provide estimates of the hour burden of the collection of information. The statement should:*

- *Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.*
- *If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13 of OMB Form 83-I.*
- *Provide estimates of annualized cost to respondents for the hour burdens for collection of information, identifying and using appropriate wage rate categories. The cost of contracting or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 13.*

Table 6 provides the estimated costs (i.e., hour burden) associated with the information collected from the grantees, while Table 7 provides those costs for client respondents. Both annual costs and the total cost over three years are included. The total cost over three years includes the administration of DCIs in years 2 and 3 of the OAHMP (all post-modification client surveys and grantee process surveys).

The burden hour per response was determined by pilot results with fewer than ten respondents. The hourly cost per response estimate is based on the cost of administration for two categories of respondents: 1) grantee managers completing DCIs required under the Evaluation; and 2) clients participating in the program:

- The $33.46 hourly cost per grantee manager response is based on the May 2020 U.S. Bureau of Labor Statistics' median annual wage reported in the Occupational Outlook Handbook for Social and Community Managers. This occupational category was selected as many of the OAHMP grantees are expected to come from community-based or nonprofit organizations. The hourly rate was based on a 40-hour work week for 52 weeks.
- The $11.31 hourly cost per client response is based on the U.S. Bureau of Labor Statistics, real average hourly earnings, March 2021, Table A-1, Current and real (constant 1982-1984 dollars) earnings for all employees on private nonfarm payrolls, seasonally adjusted.

**Table 6. Estimated Time and Costs to Grantee Respondents [f]**

| Information Collected | Number of Respondents | Frequency of Response | Responses per Annum | Burden Hour per Response | Burden Hours per Annum | Hourly Cost per Response | Annual Cost |
|---|---|---|---|---|---|---|---|
| Client Eligibility Documentation Form [a] | 4,478 | 1 | 4,478 | 0.08 | 358 | $33.46 | $11,987 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lost-to-Project Form [b] | 2,790 | 1 | 2,790 | 0.08 | 223 | $33.46 | $7,468 |
| OAHM Program Documentation of Work Completed Form [c] | 2,250 | 1 | 2,250 | 0.50 | 1,125 | $33.46 | $37,643 |
| Grantee Process Evaluation Online Survey Year 1[d] | 32 | 1 | 32 | 4.00 | 128 | $33.46 | $4,283 |
| Grantee Site Visit Interview Guide [e] | 5.3 | 2 | 10.6 | 2.00 | 21 | $33.46 | $709 |
| **Total Annual** | | | **9,560.60** | **6.66** | **1,856** | | **$62,090** |
| **Total over 3 Years** | | | | **20.00** | **5,568** | | **$186,270** |

[a.] Grantees are expected to complete the Client Eligibility Documentation form for all applicants, an estimated total of 13,433 forms over the three-year period of the OAHMP grant, or approximately 4,478 per year. This estimate is calculated based upon the assumption that 33% of applicants (approximately 4,433) will be determined ineligible for the program, and the $30 million in funding for the program will deliver home modifications to 9,000 eligible clients at an estimated average cost of $3,000 per home.

[b.] Grantees are required to complete forms for all cases lost to the evaluation, estimated at 2,790 forms per year. This total reflects the three categories of lost to follow-up from the 4,478 estimated applicants per year: 1) 33% (~1,478) expected to be determined ineligible; 2) an additional 25% (~750) expected to decline to participate in the evaluation; and 3) an additional 25% (~562) expected to be lost to project follow up by the end of the evaluation period.

[c.] Of the 3,000 clients per year, 75% (~2,250) are expected to sign the Informed Consent to participate in the evaluation.

[d.] One PM from each of up to 32 grantees will complete the Grantee Process Evaluation Online Survey annually.

[e.] The Contractor will administer the Grantee Site Visit Interview Guide to up to two grantee representatives during up to 16 site visits.

[f.] Numbers may not sum due to rounding.

| Table 7. Estimated Time and Costs to Client Respondents [f] | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Information Collection** | **Number of Respondents** | **Frequency of Response** | **Responses per Annum** | **Burden Hour per Response** | **Burden Hours per Annum** | **Hourly Cost per Response** | **Annual Cost** |
| OAHM Client Program Questionnaire (Baseline) [a] | 3000 | 1 | 3000 | 0.10 | 300 | $11.31 | $3,393 |
| OAHM Client Program Questionnaire (Post-modification) [c] | 1688 | 1 | 1688 | 0.10 | 169 | $11.31 | $1,909 |
| OAHM Program Evaluation Informed Consent [b] | 2250 | 1 | 2250 | 0.25 | 563 | $11.31 | $6,362 |
| Home Hazard Checklist (Baseline) [a] | 3000 | 1 | 3000 | 0.42 | 1260 | $11.31 | $14,251 |
| Home Hazard Checklist (Post-modification) [c] | 1688 | 1 | 1688 | 0.42 | 709 | $11.31 | $8,018 |
| OAHM Client Impact Evaluation Interview (Baseline) [b] | 2250 | 1 | 2250 | 0.33 | 743 | $11.31 | $8,398 |
| OAHM Client Impact Evaluation Interview (Post-modification) [c] | 1688 | 1 | 1688 | 0.33 | 557 | $11.31 | $6,300 |
| Script to Schedule Client Process Evaluation Interview [e] | 188 | 1 | 188 | 0.08 | 15 | $11.31 | $170 |
| Client Process Evaluation Interview [d] | 169 | 1 | 169 | 0.50 | 85 | $11.31 | $956 |
| **Total Annual** | | | **15,921** | **2.53** | **4,401** | | **$49,757** |
| **Total Over 3 Years** | | | | **7.59** | **13,197** | | **$149,271** |

[a.] The program is expected to deliver home modifications to 9,000 eligible clients over the three-year period, or 3,000 clients per year. The Client Program Questionnaire will be administered and Home Hazard Checklist conducted prior to home modification being implemented (i.e., at baseline).

[b.] Of the 3,000 clients per year, 75% (2,250) are expected to sign the Informed Consent to participate in the evaluation. The Client Impact Evaluation Interview will administered once consent is granted (i.e., at baseline).

[c.] Of the 2,250 participating clients per year, 75% (1,688) are expected to remain in the project to receive home modifications. After home modifications are complete, the Client Program Questionnaire will be re-administered, the Home Hazard Checklist will be conducted again, and the Client Impact Evaluation Interview will be repeated (i.e., post-modification).

[d.] Of the annual 1,688 clients who complete the program, 10% (169) will be interviewed about the process.

[e.] 10% of those contacted for the process interview are expected to decline; to interview 169 clients, the

Contractor expects to need to contact 188 clients.
[f.] Numbers may not sum due to rounding.

| Estimated Combined Time and Costs | | | | | |
|---|---|---|---|---|---|
| | **Annualized Total Grantee** | **Annualized Total Client** | **Annualize Total Combined** | **Total Number of Years** | **Total Over Three Years** |
| **Hours** | 1,856 | 4,401 | 6,257 | 3 | 18,771 |
| **Costs** | $62,090 | $49,757 | $111,847 | 3 | $335,541 |

## 13. Estimated Annual Burden

*Provide an estimate for the total annual cost burden to respondents or record keepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 and 14).*

- *The cost estimate should be split into two components: (a) total capital and start-up cost component (annualized over its expected useful life) and (b) a total operation and maintenance and purchase of services component. The estimates should take into account costs associated with generating, maintaining, and disclosing or providing the information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s), and the period over which costs will be incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities.*
- *If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting out information collection services should be a part of this cost burden estimate. In developing cost burden estimates, agencies may consult with a sample of respondents (fewer than 10), utilize the 60-day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.*
- *Generally, estimates should not include purchases of equipment or services, or portions thereof, made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.*

There is no anticipated cost burden to grantee or client respondents resulting from collecting Evaluation information, except those costs associated with the respondents' hourly burden represented in Tables 6 and 7. There is no charge for a grantee's use of the REDCap data entry and storage system.

## 14. Estimated Annual Cost to the Federal Government

*Provide estimates of annualized costs to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expenses that would not have been incurred without this collection of information. Agencies may also aggregate cost estimates from Items 12, 13, and 14 in a single table.*

HUD's Contractor, Healthy Housing Solutions, Inc., will provide labor and support for the research design, coordination of IRB and Office of Management and Budget (OMB) submissions, data use agreements for standardized assessment tools, sampling of respondents, REDCap fees, travel, other equipment, and overhead. All labor costs are estimated on an hourly rate; all other direct costs are based on quotations from vendors.

The current estimated cost to the Government for the Contractor's firm fixed price contract is $851,635; however, the contract's budget and period of performance is expected to be extended in fiscal year (FY) 2022. The current contract's annualized cost is $243,325. PD&R intends to submit an amended ICR in FY 2022 to reflect contract amendments.

## 15. Reasons for Program Changes

*Explain the reasons for any program changes or adjustments reported in Items 13 or 14 of the OMB Form 83-I.*

This is a new request; there are no changes or adjustments to Items 13 or 14.

## 16. Plans for Publication, Analytical Techniques, and Schedule

*For collections of information whose results will be published, outline plans for tabulation and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.*

### Plans for Publication

The purpose of this Evaluation is to improve the operations of the OAHMP and any other future grant programs for home modification services for older adults. PD&R will publish the final, HUD-approved report on the HUDuser website (https://www.huduser.gov/portal/home.html). Getting peer review of the report and preparing possible journal articles for publication were not part of the evaluation contractor's proposal and budget. HUD may consider acquiring these services in the future.

### Analytical Techniques

Analytical techniques are discussed in B.2.

**Project Schedule**

The Evaluation's current period of performance is from September 30, 2020, to March 30, 2024; OAHMP grantees' period of performance is from July 19, 2021, to July 19, 2024. (See Table 8.)

**Table 8. Estimated OAHMP Evaluation Data Collection Schedule [a]**

| Task Name | Start Date | End Date |
|---|---|---|
| OMB Approval of ICR | May 30, 2021 | September 30, 2021 |
| Grantees implement OAHMP | September 19, 2021 | July 19, 2024 |
| Grantee and Site Coordinator training | October 1, 2021 | October 31, 2021 |
| Evaluation data collection | November 1, 2021 | August 30, 2023 |
| Final Briefing for HUD | January 4, 2024 | Not applicable |
| Transfer of data files and data documentation | January 10, 2024 | March 6, 2024 |

[a] This is a draft table. It will be revised as based on expected modifications to the Evaluation's period of performance.

## 17. Expiration Date for OMB Approval

*If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.*

Not applicable; HUD will display the expiration date of OMB approval.

## 18. Exceptions to the Certification Statement

*Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.*

HUD is not requesting exceptions to the certification statement in Item 19 of OMB form 83-I.