Appendix F

OAHM Client Impact Evaluation Interview

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

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

(At baseline) **Note: THIS FORM SHOULD ONLY BE COMPLETED BY AN OT/OTA/CAPS.**

(Baseline: If client eligibility form is not complete): **WARNING: DO NOT ENTER DATA INTO THIS FORM UNTIL YOU HAVE COMPLETED THE CLIENT ELIGIBILITY FORM.**

OMB Control No. 2528-2528-0335, expiration date 5/31/2025. This form is designed to provide HUD with information about the effectiveness of its Older Adults Home Modification Grant Program. The information the client provides is voluntary. The client's home can be enrolled in the program whether they decide to participate in the evaluation or not. The public reporting burden for collection of this information is estimated to be 20 minutes per response. HUD may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

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

Section A. INFORMED CONSENT

Read Verbatim: **We are evaluating HUD's older adults home modification program to see if HUD can improve it to better meet the needs of clients like you. I would like to read you this form (***Show the client the informed consent)***. This form tells you about the Evaluation and how you can help with it. If you agree to participate in the Evaluation, I will have you sign this form. If you are physically unable to write your name, alternatives to a physical signature will be accepted** *(If an alternative is provided, please initial and indicate what the alternative is, e.g., adult child signed, spouse signed, etc. directly on the signature page)***. Taking part in the Evaluation is voluntary. You can choose not to take part in the Evaluation and still receive home modification services through the program.**

Go over the Consent Form

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

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

If A.1=No: *Read Verbatim:* **"I'm sorry you chose not to participate in the Evaluation. Thank you for taking the time to meet with me today."** *End interview and complete Section B of the lost-to-project form, checking the*

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

box "Client declined to sign the Informed Consent." *REDCap: Include a button to upload scan of signed informed consent to this form.*

Section B: Housing Tenure Questions

Ask these questions only at the baseline visit

B.1 How long have you lived in this home? *Enter number between 0 and 100 or enter -1 if not answered* *(REDCap: Allow decimal places)*	____ Years ☐ Not answered
B.1a Thinking about your future years, are you more likely to move to a different community, move to a different residence within your current community, or stay in your current home and never move? *Check only one* (AARP Q5, 2020)	☐ Move to a different community ☐ Move into a different residence within my current community ☐ Stay in my current home and never move ☐ Not sure ☐ Not answered
B.1b How important is it for you to remain in this home for as long as possible? *Check only one* (AARP Q8, 2020)	☐ Extremely important ☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not at all important ☐ Not sure ☐ Not answered
B.1c How important is it for you to be able to live independently in this home as you age? *Check only one* (Q11, 2020)	☐ Extremely important ☐ Very important ☐ Somewhat important ☐ Not very important ☐ Not at all important ☐ Not answered

Section C. HEALTH AND UNPLANNED HEALTHCARE USE

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

C.1 Would you say that, in general, your health is *Check only one* (NHATS):	☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Not answered
C.2 What in-home healthcare services do you currently receive? *Check all that apply*	☐ Home visits from Occupational Therapist *Do not include OAHM Program OT or OTA home visits* ☐ Home visits from Physical Therapist ☐ Home visits from Nurse ☐ Home visits from other health care provider ☐ None*(If any of the first 4 responses are checked, then do not allow "None" or "Not Answered" to be checked. Do not allow both "None" and "Not answered" to be checked.)* ☐ Not answered
C.3 What are some of the main medical issues you	☐ Arthritis

currently see a doctor for? *Do not read answer choices to the client. Check all that the client mentions.*	☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Difficulty in thinking or remembering things *Explain this refers to cognition issues; for example, confusion or memory loss that is happening more often or getting worse, such as forgetting how to do things you've always done or forgetting things that you would normally know how to do. (CDC)* ☐ COPD or other chronic respiratory issue ☐ Vision issue *(Open this dropdown list if vision box is checked:* Client's wording for vision issue: ☐ blind ☐ legally blind ☐ limited vision ☐ low vision ☐ partially sighted Other (Specify): ☐ Hearing issue *(Open this dropdown list if hearing box is checked:* Client's wording for hearing issue: ☐ hard of hearing ☐ hearing loss ☐ deaf ☐ partially deaf ☐ Other (Specify): ☐ Speech issue *(Open this dropdown list if hearing box is checked:* Client's wording for hearing issue: ☐ stuttering ☐ stammering ☐ trouble speaking or talking ☐ voice problems ☐ Other (Specify): _____ ☐ Chronic problems with legs or feet ☐ Other medical issues (specify): _____ ☐ None *(If any medical issues are checked, then "None" and "Not Answered" should not be checked.. Do not allow both "None" and "Not answered" to be checked.)* ☐ Not answered
C.4 How much does pain interfere with your normal everyday activities? *Hand client answer Card E and explain the scale, i.e., 1=does not interfere, 10=interferes completely*	Answer *(between 1 and 10)*: _____

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

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

C.6. In the past year, have you had a major medical event requiring you to have unplanned medical care calls or visits?	☐ Yes *(Go to 6a)* ☐ No *(Go to Section D)* ☐ Not answered *(Go to Section D)*
C.6.a. How many of these unplanned medical care calls or visits were **due to falls or non-fall injuries that happened to you in your home or on your property**??	☐ 0 *(Go to Section D)* ☐ 1 *(Go to 6b)* ☐ 2 *(Go to 6b)* ☐ 3 *(Go to 6b)* ☐ 4 or more times *(Go to 6b)* ☐ Not answered *(Go to Section D)*
C.6.b. Please list the approximate dates the fall(s) or non-fall injury(ies) occurred. The month and year are sufficient.	*(The number of dates will open in REDCap according to the number of events specified in C.6.a.)* Date 1: _____ Date 2: _____ Date 3: _____ Date 4: _____

Section C.7(1): [Number in parentheses should correspond with call or visit number] Details of the (FIRST) unplanned medical care call or visit. Complete this block If C.6=Yes and C.6a≥1, up to 4 events. Replace "first" with "second," "third," and "fourth" as appropriate.

Read Verbatim: **Now I will ask you for some details about the injury in your home or on your property on "[INSERT DATE]".**

C.7(1).a. *[Number in parentheses should correspond with call or visit number]* For the event on [DATE], did emergency medical services (for example, an ambulance or the fire department) come to your home?	☐ Yes *(Go to C.7(1).c)* ☐ No *(Go to C.7(1).b)* ☐ Not answered
C.7(1).b. Did you GO TO an Emergency Room, Urgent Care Center, or Primary Care Physician/Specialist? *Check all that apply. For example, if the client went to the urgent care and was then sent to ER, check both urgent care and emergency room. (Regardless of response, go to C.7(1).c)*	☐ Primary Care Physician or Specialist ☐ Emergency Room ☐ Urgent Care Center ☐ No ☐ Not answered
C.7(1).c What was the reason for this *[FIRST]* unplanned visit? *Check all that apply.*	☐ Fall. ☐ Non-Fall Injury. ☐ Burn ☐ Cut ☐ Struck by / dropped object (e.g., pot or chair, door, cabinet) ☐ Other. Please describe:_____

	☐ Not answered
C.7(1).d. Did you spend at least one night in the hospital?	☐ Yes ☐ No *(If C.6a>1, go to next unplanned medical event; if C.6a=1, go to Section D)* ☐ Not answered *(If C.6a>1, go to next unplanned medical care event; if C.6a=1, go to Section D)*
C.7(1).d(i). How many nights were you in the hospital? *Enter # of nights between 1 and 250 or enter -1 if not answered. If the person gives their answer in months, convert to nights using a conversion factor of 30 days/month.*	_____
C.7(1).d(ii). When you left the hospital, did you stay somewhere other than your current home (e.g., relative's home, rehab facility, nursing home) to recover before returning to your home? *If "yes" is answered, ask location. Check only one.*	☐ Yes *(REDCap: Open dropdown list below. After location is checked go to* C.7(1).d.(ii).a.*)* ☐ Nursing home ☐ Rehabilitation center ☐ Friend or relative's home ☐ Other location. Specify: ___ ☐ No (*Go to C.7(1).d(iii))* ☐ Not answered
C.7(1).d(ii).a. How many nights did you stay there? *Enter # of nights between 0 and 250 or enter -1 if not answered. If the person gives their answer in months, convert to nights using a conversion factor of 30.42 days/month. REDCap: List an error message if they say 0 nights*	___
C.7(1).d(iii). How concerned were you about returning to your home after this unplanned major medical event? *(If C.6a>1, go to C.6.b for next unplanned event; if C.6a=1, go to Section D)*	☐ Extremely concerned ☐ Very concerned ☐ Somewhat concerned ☐ Not very concerned ☐ Not at all concerned ☐ Not answered

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

Hand the participant PAGE 1 of the of the EQ-5D-3L.

Read Verbatim: **"Here are some questions for you to answer. By placing a checkmark in or pointing to one box in each group on the paper, please indicate which statements best describe your own health state today. Then hand the paper back to me."** *Each time the person tells you or points to an answer, record it below. Only one answer is permitted per question. (Allow only one answer to be checked for each question.)*

D.1. Mobility	☐ I have no problems in walking about ☐ I have some problems in walking about ☐ I am confined to bed
D.2. Self-Care	☐ I have no problems with self-care ☐ I have some problems washing or dressing myself. ☐ I am unable to wash or dress myself
D.3. Usual activities (e.g., work, study, housework, family, or leisure activities)	☐ I have no problems with performing my usual activities ☐ I have some problems with performing my usual activities

	☐ I am unable to perform my usual activities
D.4. Pain/Discomfort	☐ I have no pain or discomfort ☐ I have moderate pain or discomfort ☐ I have extreme pain or discomfort
D.5. Anxiety/Depression	☐ I am not anxious or depressed ☐ I am moderately anxious or depressed ☐ I am extremely anxious or depressed
D.6 *Hand page 2 of the EQ-5D-3L to the client and read:* **"We would like to know how good or bad your health is TODAY. This scale is numbered from 0 to 100. 100 means the best health you can imagine, 0 means the worst health you can imagine. Please tell me or [point] on the scale to indicate how your health is today."** *The participant can "draw" with a finger from the "Your own health state today" box to the point on the scale. Record this value between 0 and 100.*	___ Score

Section E: Life-Space Assessment (UAB Study of Aging Life-Space Assessment™ 2008):

Read the frequency choices when asking about each level.

These questions refer to your activities just within the past month			
During the past four weeks, have you been to...	**Response**	**How often did you get there?**	**Did you need help from another person and/or equipment?** *Both personal assistance and equipment can be selected (Do not allow "no equipment" or "personal assistance" to be selected if other boxes are selected)*
E.1 Other rooms of your home besides the room where you sleep?	E.1A ☐ YES ☐ NO	E.1B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.1C ☐ personal assistance ☐ equipment ☐ no equipment or personal assistance
E.2 An area outside your home such as your porch, deck or patio, hallway (of an apartment building) or garage, in your own yard or driveway?	E.2A ☐ YES ☐ NO	E.2B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.2C ☐ personal assistance ☐ equipment ☐ no equipment or personal assistance
E.3 Places other than your own yard or apartment building, in your neighborhood, town, or outside of your town?	E.3A ☐ YES ☐ NO	E.3B ☐ Less than 1/ week ☐ 1-3 times /week ☐ 4-6 times/week ☐ daily	E.3C ☐ personal assistance ☐ equipment ☐ no equipment or personal assistance

Section F: The Patient Health Questionnaire NHATS

Hand participant answer Card F and read the answer choices before asking the question F.1.

Read Verbatim: **"Over the last month, how**	**Not at all**	**Several Days**	**More than half the days**	**Nearly Every Day**	**Don't Know**	**Refused**

often have you:	**(0)**	**(1)**	**(2)**	**(3)**		
F.1 Had little interest or little pleasure in doing things?	☐	☐	☐	☐	☐	☐
F.2 Felt down, depressed, or hopeless?	☐	☐	☐	☐	☐	☐
F.3 Felt nervous, anxious, or on edge?	☐	☐	☐	☐	☐	☐
F.4 Been unable to stop or control worrying?	☐	☐	☐	☐	☐	☐

If any of questions F.1 through F.4 were not answered, go back to try to obtain answers to all questions.

Section G: ACTIVITIES OF DAILY LIVING QUESTIONS *(US Centers for Medicare and Medicaid, 2020 [https://www.hosonline.org/globalassets/hos-online/survey-instruments/hos_2020_survey_English.pdf], National Health and Aging Trends Survey (NHATS), and Retirement Study (HRS))*

HAND THE CLIENT CARD G.

Read Verbatim: **"The next few questions are about your ability to do everyday activities without help. By help, I mean either the help of another person, including the people who live with you, or the help of special equipment. Do you have any problem..."**

	No, I do not have difficulty	**Yes, I have difficulty**	**I am unable to do this activity**	**Don't Know**	**Refused**
G.1 Bathing/Showering without help	☐	☐	☐	☐	☐
G.2 Dressing without help	☐	☐	☐	☐	☐
G.3 Eating without help	☐	☐	☐	☐	☐
G.4 Getting in or out of chairs without help	☐	☐	☐	☐	☐
G.5 Getting in or out of bed without help	☐	☐	☐	☐	☐
G.6 Using the toilet without help	☐	☐	☐	☐	☐
G.7 Walking around inside without help	☐	☐	☐	☐	☐
Read verbatim: ***"Because of a health problem, do you have any difficulty with the following*** **activities?"** *(Allow only one answer to be checked for each question*					
G.8. Pulling or pushing large objects like a living room chair or a vacuum	☐	☐	☐	☐	☐
G.9. Climbing several flights of stairs	☐	☐	☐	☐	☐

Section H: INSTRUMENTAL ACTIVITIES OF DAILY LIVING[2] *(US Centers for Medicare and Medicaid 2020 [https://www.hosonline.org/globalassets/hos-online/survey-instruments/hos_2020_survey_English.pdf] and National Health and Aging Trends Survey (NHATS)*

HAND THE CLIENT CARD H.

Read Verbatim: **"Because of a health or physical problem, do you have difficulty doing the following activities?"**

	No, I do not have difficulty	Yes, I have difficulty	I don't do this activity	Don't Know	Refused
H.1 Preparing meals	☐	☐	☐	☐	☐
H.2 Managing money	☐	☐	☐	☐	☐
H.3 Taking medication as prescribed	☐	☐	☐	☐	☐
H.4 Doing laundry	☐	☐	☐	☐	☐
H.5 Doing light housework	☐	☐	☐	☐	☐
H.6 Shopping for groceries	☐	☐	☐	☐	☐
H.7 Making telephone calls	☐	☐	☐	☐	☐

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

Section I: Staff Notes and Comments

I.1 Length of the interview in minutes: _____

(REDCap: Questions I.2 through I.5 are optional and should only be included on the baseline form.)

Grantee Guidance: Questions I.1 through I.5 are optional. Answer these questions yourself after you leave the client's home. In general, this information may help other staff determine steps they may need to take when interacting with the client.

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

I.5 Additional Interviewer Comments	

CLIENT IMPACT EVALUATION ANSWER CARDS

IMPACT EVALUATION INTERVIEW CARD E

Scale of 1 to 10:

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

Does Not Interfere	Moderately Interferes	Interferes Completely

IMPACT EVALUATION INTERVIEW ANSWER CARD F

Not at all

Several days

More than half the days

Nearly every day

Don’t know

IMPACT EVALUATION INTERVIEW ANSWER CARD G

No, I do not have difficulty

Yes, I have difficulty

I am unable to do this activity

Don’t know

IMPACT EVALUATION INTERVIEW ANSWER CARD H

No, I do not have difficulty

Yes, I have difficulty

I don’t do this activity

Don’t know