

Appendix F

OAHM Client Impact Evaluation Interview

Older Adults Home Modification Program Client Impact Evaluation Interview¹

Study ID			Visit	Today's Date (mm/dd/yyyy)	Form Completed By:	
Site ID	Field Team ID	Client ID			Name	Job Title
			<input type="checkbox"/> Baseline <input type="checkbox"/> 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? <i>Enter number between 0 and 100 or enter -1 if not answered</i> (REDCap: Allow decimal places)	____ Years <input type="checkbox"/> 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? <i>Check only one</i> (AARP Q5, 2020)	<input type="checkbox"/> Move to a different community <input type="checkbox"/> Move into a different residence within my current community <input type="checkbox"/> Stay in my current home and never move <input type="checkbox"/> Not sure <input type="checkbox"/> Not answered
B.1b How important is it for you to remain in this home for as long as possible? <i>Check only one</i> (AARP Q8, 2020)	<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Somewhat important <input type="checkbox"/> Not very important <input type="checkbox"/> Not at all important <input type="checkbox"/> Not sure <input type="checkbox"/> Not answered
B.1c How important is it for you to be able to live independently in this home as you age? <i>Check only one</i> (Q11, 2020)	<input type="checkbox"/> Extremely important <input type="checkbox"/> Very important <input type="checkbox"/> Somewhat important <input type="checkbox"/> Not very important <input type="checkbox"/> Not at all important <input type="checkbox"/> 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 <i>Check only one</i> (NHATS):	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Not answered
C.2 What in-home healthcare services do you currently receive? <i>Check all that apply</i>	<input type="checkbox"/> Home visits from Occupational Therapist <i>Do not include OAHM Program OT or OTA home visits</i> <input type="checkbox"/> Home visits from Physical Therapist <input type="checkbox"/> Home visits from Nurse <input type="checkbox"/> Home visits from other health care provider <input type="checkbox"/> 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.) <input type="checkbox"/> Not answered
C.3 What are some of the main medical issues you	<input type="checkbox"/> Arthritis

<p>currently see a doctor for? <i>Do not read answer choices to the client. Check all that the client mentions.</i></p>	<ul style="list-style-type: none"><input type="checkbox"/> Diabetes<input type="checkbox"/> Cancer<input type="checkbox"/> Heart Disease<input type="checkbox"/> Difficulty in thinking or remembering things <i>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)</i><input type="checkbox"/> COPD or other chronic respiratory issue<input type="checkbox"/> Vision issue <i>(Open this dropdown list if vision box is checked:</i> Client's wording for vision issue:<ul style="list-style-type: none"><input type="checkbox"/> blind<input type="checkbox"/> legally blind<input type="checkbox"/> limited vision<input type="checkbox"/> low vision<input type="checkbox"/> partially sightedOther (Specify): _____<input type="checkbox"/> Hearing issue <i>(Open this dropdown list if hearing box is checked:</i> Client's wording for hearing issue:<ul style="list-style-type: none"><input type="checkbox"/> hard of hearing<input type="checkbox"/> hearing loss<input type="checkbox"/> deaf<input type="checkbox"/> partially deaf<input type="checkbox"/> Other (Specify): _____<input type="checkbox"/> Speech issue <i>(Open this dropdown list if hearing box is checked:</i> Client's wording for hearing issue:<ul style="list-style-type: none"><input type="checkbox"/> stuttering<input type="checkbox"/> stammering<input type="checkbox"/> trouble speaking or talking<input type="checkbox"/> voice problems<input type="checkbox"/> Other (Specify): _____<input type="checkbox"/> Chronic problems with legs or feet<input type="checkbox"/> Other medical issues (specify): _____<input type="checkbox"/> None <i>(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.)</i><input type="checkbox"/> Not answered
<p>C.4 How much does pain interfere with your normal everyday activities? <i>Hand client answer Card E and explain the scale, i.e., 1=does not interfere, 10=interferes completely</i></p>	<p>Answer <i>(between 1 and 10)</i>: _____</p>

	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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.5b Walker to help you move inside your home and on your property?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.5c Cane to help you move inside your home and on your property?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>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.”</p>						
C.6. In the past year, have you had a major medical event requiring you to have <u>unplanned medical care calls or visits</u> ?	<input type="checkbox"/> Yes (Go to 6a) <input type="checkbox"/> No (Go to Section D) <input type="checkbox"/> 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 ??	<input type="checkbox"/> 0 (Go to Section D) <input type="checkbox"/> 1 (Go to 6b) <input type="checkbox"/> 2 (Go to 6b) <input type="checkbox"/> 3 (Go to 6b) <input type="checkbox"/> 4 or more times (Go to 6b) <input type="checkbox"/> Not answered (Go to Section D)					
C.6.b. Please list the <u>approximate</u> dates the fall(s) or non-fall injury(ies) occurred. The month and year are sufficient.	<p>(The number of dates will open in REDCap according to the number of events specified in C.6.a.)</p> Date 1: _____ Date 2: _____ Date 3: _____ Date 4: _____					
<p>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.</p> <p>Read Verbatim: Now I will ask you for some details about the injury in your home or on your property on “[INSERT DATE]”.</p>						
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?	<input type="checkbox"/> Yes (Go to C.7(1).c) <input type="checkbox"/> No (Go to C.7(1).b) <input type="checkbox"/> Not answered					
C.7(1).b. Did you GO TO an Emergency Room, Urgent Care Center, or Primary Care Physician/Specialist? <i>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)</i>	<input type="checkbox"/> Primary Care Physician or Specialist <input type="checkbox"/> Emergency Room <input type="checkbox"/> Urgent Care Center <input type="checkbox"/> No <input type="checkbox"/> Not answered					
C.7(1).c What was the reason for this [FIRST] unplanned visit? <i>Check all that apply.</i>	<input type="checkbox"/> Fall. <input type="checkbox"/> Non-Fall Injury. <input type="checkbox"/> Burn <input type="checkbox"/> Cut <input type="checkbox"/> Struck by / dropped object (e.g., pot or chair, door, cabinet) <input type="checkbox"/> Other. Please describe: _____					

	<input type="checkbox"/> Not answered
C.7(1).d. Did you spend at least one night in the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If C.6a>1, go to next unplanned medical event; if C.6a=1, go to Section D) <input type="checkbox"/> 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.	<input type="checkbox"/> Yes (REDCap: Open dropdown list below. After location is checked go to C.7(1).d.(ii).a.) <input type="checkbox"/> Nursing home <input type="checkbox"/> Rehabilitation center <input type="checkbox"/> Friend or relative’s home <input type="checkbox"/> Other location. Specify: ____ <input type="checkbox"/> No (Go to C.7(1).d.(iii)) <input type="checkbox"/> 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)	<input type="checkbox"/> Extremely concerned <input type="checkbox"/> Very concerned <input type="checkbox"/> Somewhat concerned <input type="checkbox"/> Not very concerned <input type="checkbox"/> Not at all concerned <input type="checkbox"/> 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	<input type="checkbox"/> I have no problems in walking about <input type="checkbox"/> I have some problems in walking about <input type="checkbox"/> I am confined to bed
D.2. Self-Care	<input type="checkbox"/> I have no problems with self-care <input type="checkbox"/> I have some problems washing or dressing myself. <input type="checkbox"/> I am unable to wash or dress myself
D.3. Usual activities (e.g., work, study, housework, family, or leisure activities)	<input type="checkbox"/> I have no problems with performing my usual activities <input type="checkbox"/> I have some problems with performing my usual activities

	<input type="checkbox"/> I am unable to perform my usual activities
D.4. Pain/Discomfort	<input type="checkbox"/> I have no pain or discomfort <input type="checkbox"/> I have moderate pain or discomfort <input type="checkbox"/> I have extreme pain or discomfort
D.5. Anxiety/Depression	<input type="checkbox"/> I am not anxious or depressed <input type="checkbox"/> I am moderately anxious or depressed <input type="checkbox"/> I am extremely anxious or depressed
D.6 <i>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.</i>	___ 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	E.1B <input type="checkbox"/> Less than 1/ week <input type="checkbox"/> 1-3 times /week <input type="checkbox"/> 4-6 times/week <input type="checkbox"/> daily	E.1C <input type="checkbox"/> personal assistance <input type="checkbox"/> equipment <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	E.2B <input type="checkbox"/> Less than 1/ week <input type="checkbox"/> 1-3 times /week <input type="checkbox"/> 4-6 times/week <input type="checkbox"/> daily	E.2C <input type="checkbox"/> personal assistance <input type="checkbox"/> equipment <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	E.3B <input type="checkbox"/> Less than 1/ week <input type="checkbox"/> 1-3 times /week <input type="checkbox"/> 4-6 times/week <input type="checkbox"/> daily	E.3C <input type="checkbox"/> personal assistance <input type="checkbox"/> equipment <input type="checkbox"/> 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.

<i>Read Verbatim:</i> “Over the last month, how	Not at all	Several Days	More than half the days	Nearly Every Day	Don’t Know	Refused
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often have you:	(0)	(1)	(2)	(3)		
F.1 Had little interest or little pleasure in doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.2 Felt down, depressed, or hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.3 Felt nervous, anxious, or on edge?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.4 Been unable to stop or control worrying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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](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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.2 Dressing without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.3 Eating without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.4 Getting in or out of chairs without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.5 Getting in or out of bed without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.6 Using the toilet without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.7 Walking around inside without help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G.9. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section H: INSTRUMENTAL ACTIVITIES OF DAILY LIVING² (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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.2 Managing money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.3 Taking medication as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.4 Doing laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.5 Doing light housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.6 Shopping for groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.7 Making telephone calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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)?	<input type="checkbox"/> No <input type="checkbox"/> 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)?	<input type="checkbox"/> No <input type="checkbox"/> 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)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
I.4a If yes, please explain.	

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I.5 Additional Interviewer Comments	
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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 Moderately Interferes
Not Interferes Completely
Interfere

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