

Healthy Aging Assessment

Timing:

Section A – Baseline only

Section B – Baseline and 3 months

Section C – Baseline and 6 months

Section D – Baseline and 6 months

SECTION A: Getting to Know You

Please answer the questions in this section to the best of your ability. This is important information to help us understand who is using the program so that we can make sure we are meeting your needs and the needs of the community. As more information is gathered, we will be able to better personalize your experience with the program!

1. Age
 - add drop down menu

If greater or equal to 65, present full form; If less than 65 present section A and B only)

2. What is your gender?
Gender refers to social roles and expectations, behaviors, expressions, and identities of girls, women, boys, men, and gender-diverse people.
 - a) Man
 - b) Woman
 - c) I identify as _____
 - d) Prefer not to say
3. Please enter the first 3 digits of your postal code
 - a) enter text

People of different ethnicities do not have significantly different genetics. But our ethnicity still has important consequences, including how we are treated by different individuals and institutions.

4. Which ethnicity category best describes you? Check all that apply:
 - a. Black
 - b. East/Southeast Asian
 - c. Indigenous (Including First Nations, Metis, Inuk/Inuit)
 - d. Latino
 - e. Middle Eastern
 - f. South Asian
 - g. White
 - h. Other
 - i. Prefer not to answer

If answered c:

Do you identify as First Nations, Metis, or Inuk/Inuit? (check all that apply)

- a.) First Nations
- b.) Metis
- c.) Inuk/Inuit
- d.) No
- d.) Prefer not to answer
- d.) Other ____ Free text ____

5. In general, which is your most common form of transportation?
 - a. Passenger in a motor vehicle
 - b. Drive a motor vehicle
 - c. Taxi or similar paid services
 - d. Public transportation such as bus, rapid transit, subway or train

- e. Accessible transit
 - f. Cycling
 - g. Walking
 - h. Wheelchair or motorized cart
6. What is your total household income? Include all sources of income before taxes and deductions. [*drop down menu*](#)
- a. Under \$10,000
 - b. \$10,000 to \$24,999
 - c. \$25,000 to \$49,999
 - d. \$50,000 to \$74,999
 - e. \$75,000 to \$99,999
 - f. \$100,000 or more
 - g. Prefer not to say

An assistive device is any device or tool designed or adapted to help a person perform a particular task or activity.

7. Do you use any aids and/or assistive devices for moving around, to help with bending or reaching or to help with fine motor skills? Select all that apply.
- a. a cane, a walking stick or crutches
 - b. a walker
 - c. a scooter
 - d. a manual wheelchair
 - e. a motorized wheelchair
 - f. orthopedic footwear
 - g. an orthotic or a brace
 - h. a prosthetic device or an artificial limb
 - i. a grasping tool or a reach extender
 - j. adapted tools, utensils or special grips
 - k. a device for dressing (e.g., button hook, zipper pull, long-handled shoe horn)
 - l. a device with oversized buttons (e.g., remote control or telephone)
 - m. None
8. What is your living arrangement?
- a) Living alone
 - b) Living with partner (with or without children)
 - c) Living with relatives and non-relatives
 - d) Prefer not to say
9. What is your highest level of education level?
- a. No certificate, diploma, or degree
 - b. Secondary (high school) diploma or equivalency certificate
 - c. Apprenticeship or trades certificate or diploma
 - d. College, CEGEP, or non-university certificate or diploma
 - e. University certificate or diploma below bachelor level
 - f. University certificate, diploma, or degree at bachelor level or above
 - g. Prefer not to say
10. What is your employment status?
- a. Employed
 - b. Unemployed
 - c. I am permanently unable to work
 - d. I volunteer or look after children or other family members
 - e. I am retired
 - f. Other (specify): _____

Thank you for answering these questions! Next, we would like to understand your technology access and use:

11. In the past 12 months, have you used any technology or digital device to help you monitor or manage certain aspects of your health and well-being?
- a) Yes
 - b) No
 - a) If yes, please specify what technology or device: _____
12. Do you feel comfortable using technology in your everyday life?
- a) Yes
 - b) No Tag: Cyber Seniors
13. How often do you experience internet connectivity issues?
- a) Never
 - b) On occasion
 - c) Often, my internet connection is not reliable
14. How did you hear about the AVOID Frailty program?
- a) Canadian Frailty Network website
 - b) Poster, flyer, or pamphlet at community venue
 - a) If you remember the location, please specify: _____
 - c) Newspaper
 - d) Postcard received in the mail
 - e) Social media
 - a) Please specify platform: Facebook, Twitter, LinkedIn, or other
 - f) Healthcare provider
 - g) Word of mouth
 - h) Other
 - a) Please specify: _____

SECTION B: Behavioural Self-Assessment

The following section will ask you about your health-related behaviours and lifestyle. The answers will be used to personalize your

program experience based on the specific supports that you need and the challenges that you face. Please answer these questions to the best of your ability and recollection.

ACTIVITY

15. During the last 7 days, how much time did you spend sitting during the day?
- Some of the day
 - Most of the day
 - All day
16. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?
- Most days (5-7 days)
 - Some days (2-4 days)
 - Rarely or not at all
17. During the last 7 days, on how many days did you do moderate physical activities like gardening, cleaning, bicycling at a regular pace, swimming, or other fitness activities?
- Most days (5-7 days)
 - Some days (2-4 days)
 - Rarely or not at all

If answered c to 15, 16 or 17:

What is the hardest part of staying active for you? (choose all that apply)

- a.) I am physically and/or mentally unable to be active Tag: peer coaching participant
b.) I don't know where/how to get help in my community Tag: activity programs
c.) I have trouble maintaining a routine when it comes to activity Tag: activity module, Ingredients for change module
d.) Other ____ Free text ____

VACCINATE

18. Have you ever been told by a healthcare provider that you should not be vaccinated?
- Yes
 - No

If Yes to question 18: Please let us know the reason for this if you are comfortable doing so
____ Free Text ____ AND

If Yes to question 18: skip questions 19-26 + refer to healthcare provider

19. Have you had your annual flu vaccine this year?
- Yes
 - No
20. Have you had a shingles vaccine? (once after age 50)
- Yes
 - Shingrix
 - Zostavax II
 - Unsure
 - No
21. Have you had a pneumonia vaccine? (once at age 65)
- Yes (if yes will need to ask if they know which one)
 - No
22. Are your booster vaccines up to date? (Tetanus & Diphtheria – every 10 years)
- Yes
 - No

23. Have you had two doses of the COVID-19 vaccine?
- a) Yes
 - b) No
- a) **If Yes: Have you had your COVID-19 booster vaccine?**

If answered No to any of questions 19-23:

What is the main reason that you have not had all of the recommended vaccinations listed above? (choose all that apply)

- a.) I was not aware of the recommended vaccines Tag: vaccination module
- b.) I don't know where or how to get vaccinated Tag: vaccination programs, peer coaching participant
- c.) I don't see the point of getting vaccinated Tag: vaccination module
- d.) Other ____ Free text ____

OPTIMIZE MEDICATION

24. How many prescription medications do you take?
- a) 0-4
 - b) 5 or more
25. How many over the counter medications, including supplements/vitamins do you take on a daily basis?
- a) 0-4
 - b) 5 or more
26. Have you had your medications (including prescriptions, over the counter, and supplements) reviewed by a pharmacist or healthcare provider in the last year?
- a) Yes
 - b) No
 - c) N/A

If answered no to question 26:

Why have you not had your medication reviewed in the last year? (choose all that apply)

- a.) I was not aware that this is recommended Tag: optimize medication, optimize medication module
- b.) I do not feel comfortable and/or prepared to have this conversation with a healthcare provider Tag: Peer coaching participant, MedTrack
- c.) I do not know who to talk to about this Tag: optimize medication programs
- d.) I have had my medication reviewed in the past, but find it hard to remember each year Tag: Peer coaching participant
- e.) I do not understand why this is important Tag: optimize medication, optimize medication module
- f.) Other ____ Free text ____

INTERACT (Adapted with permission from Lubben Scale)

Family: Considering the people that you regard as family

	none	1	2	3-4	5-8	9+
27. How many relatives do you see or hear from at least once a month?						
28. How many relatives do you feel at ease with that you can talk about private matters?						
29. How many relatives do you feel close to such that you could call on them for help?						

Friends: Considering the people that you regard as friends

	none	1	2	3-4	5-8	9+
30. How many friends do you see or hear from at least once a month?						
31. How many friends do you feel at ease with that you can talk about private matters?						
32. How many friends do you feel close to such that you could call on them for help?						

Scoring guide: none = 0 / one = 1 / two = 2 / three-four = 3 / five-eight = 4 / nine+ = 5

If score < 12:

What have been your main challenge when it comes to social interaction (choose all that apply)

- a) I have been restricted due to COVID-19 public health measures Tag: Cyber Seniors, Peer coaching participant
- b) I find it physically/mentally difficult to participate in social interactions Tag: peer coaching participant,
- c) I am not aware of opportunities for social interaction in my community Tag: interact programs, health connections
- d) I have trouble maintaining social connections over time Tag: interact programs, peer coaching participant
- e) I do not feel that I need more interaction than I already have Tag: interact module, Interaction Vid
- f) Other ____Free text____

33. How often do you feel that you lack companionship?

- a) Hardly ever
- b) Some of the time
- c) Often

34. How often do you feel left out?

- a) Hardly ever
- b) Some of the time
- c) Often

35. How often do you feel isolated from others?

- a) Hardly ever
- b) Some of the time
- c) Often

DIET AND NUTRITION

33. Do you eat foods high in protein (e.g., meat, poultry, fish, eggs, and dairy foods) with every meal?

- a) Yes
- b) No

34. At meal times, is half your plate usually filled with fruits and vegetables?

- a) Yes
- b) No

35. Do you eat foods high in calcium every day?

(Recommended Dietary Allowance: 1000-1200mg daily *1 cup cow's milk = 200mg, 3/4 cup yogurt = 250mg, 1 oz. cheese = 200mg)

- a) Yes
- b) No

36. Do you take a vitamin D supplement?

- a) Yes
- b) No

If answered No to any of questions 33-36:

What is the hardest part of maintaining a balanced diet for you? (choose all that apply)

- a) I find it physically/mentally difficult to do this Tag: peer coaching participant, dietitian services
- b) I was not aware of one or more of the recommendations in the questions above Tag: diet and nutrition module
- c) It's difficult for me to access nutritious and/or culturally appropriate food because of where I live Tag: diet and nutrition programs, driving programs
- d) I can't afford the type of food that I would like to eat Tag: food banks and stands
- e) I have trouble maintaining a healthy eating routine Tag: Peer coaching participant, dietitian services
- f) Other ____Free text____

READINESS FOR CHANGE

37. To better understand what you aim to achieve with the AVOID Frailty Program, please select which of the following statements best describes you in relation to each of the components of AVOID:

	I don't think I need to make a change in this area but am still interested in what this program has to offer (pre-contemplation)	I am interested in changing my lifestyle in this area and need some help getting started (contemplation)	I am interested in changing my lifestyle in this area and would like to start planning my first steps (preparation)	I am already engaged in some healthy behaviours in this area, but want to create lasting habits (action)	I am already engaged in health behaviours and am interested to continue to improve even more (maintenance)
Activity					
Vaccination					
Optimized Medication Use					
Social Interaction					
Diet and Nutrition					

If contemplation or preparation in all, Tag: Peer coaching participant

If action or maintenance in all, Tag: Peer coaching volunteer

SECTION C: Health Related Quality of Life

The AVOID Frailty Program aims to support you in improvements to your physical and social wellbeing. The questions in this section will help us to understand these aspects of your life before you start the program, and we will ask again in 6 months to see if anything has changed.

Under each heading, please tick the ONE box that best describes your health today

38. MOBILITY

- I have no problems in walking about
- I have slight problems in walking about
- I have moderate problems in walking about
- I have severe problems in walking about
- I am unable to walk about

39. SELF-CARE

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

40. USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

41. PAIN / DISCOMFORT

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

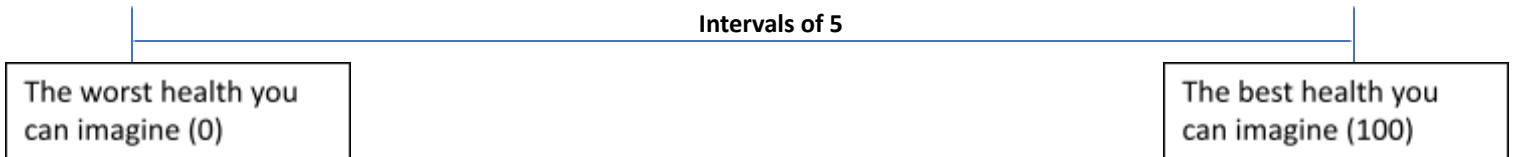
42. ANXIETY / DEPRESSION

- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed

43. 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.

Mark an X on the scale to indicate how your health is TODAY.



Now, please write the number you marked on the scale in the box below. (or indicate on drop down list?)

SECTION D: Health and Frailty Status

This final section will ask questions about your specific health and frailty status before you start the program. We hope to stop or slow down the progression of frailty by providing you with the support that you need in your community. We will ask you these questions again in 6 months to see if anything has changed.

44. During the past week, how often have you felt that everything was an **effort** or you **could not get going**?
- a) Rarely
 - b) Occasional amount
 - c) Most of the time
45. During your waking time, how often do you feel **tired or fatigued**?
- a) Rarely
 - b) Occasional amount
 - c) Most of the time
46. Over the past two weeks have you been bothered by not being able to stop or control **worrying**?
- a) Not at all
 - b) Several days
 - c) More days than not
47. Over the past two weeks have you been bothered by **little interest or pleasure in doing things**?
- a) Not at all
 - b) Several days
 - c) More days than not
48. How would you rate your memory overall?
- a) Good
 - b) Fair
 - c) Poor
49. How many falls (including slips, trips, and falls to the ground) did you have in the last year?
- a) No falls
 - b) 1 fall Tag: Balance
 - c) 2 or more falls Tag: Falls
50. Do you have any problems keeping your balance?
- a) No

b) Yes Tag: Movement and Mindfulness Programs; Balance

51. Which of the following best describes your walking speed?

- a) Normal or brisk
- b) Stroll at an easy pace
- c) Very slow/unable to walk

52. Is the distance that you are able to walk limited by your health?

- a) No
- b) Yes, please indicate distance
 - a) Less than 1 kilometer occasionally
 - b) Less than 1 kilometer most days
 - c) Less than 100 meters occasionally
 - d) Less than 100 meters most days

53. During the past month how would you rate your sleep quality overall?

- a) Good
- b) Bad

54. Has your food intake decreased over the last 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

- a) No
- b) Yes

55. Have you lost more than 3kg in weight over the last 3 months?

- a) No
- b) Yes
- c) Don't know

56. Have you had any pain in your mouth while chewing?

- a) No
- b) Yes

57. Have you had to interrupt meals because of problems with poorly fitting dentures, not enough teeth, or a dry mouth?

- a) No
- b) Yes

58. How much **bodily pain** have you had during the past four weeks?

- a) None or mild
- b) Moderate
- c) Severe

59. Do you have pain in your feet:

- a) Rarely
- b) Occasional amount
- c) Most of the time

60. Do you experience problems in your daily life due to weakness in your hands?

- a) No
- b) Sometimes
- c) Yes

61. Do you experience problems in your daily life due to weakness in your legs or feet?

- a) No
- b) Sometimes
- c) Yes

62. During the last 3 months, have you leaked urine (even a small amount)?

- a) No

b) Yes

63. Do you have any of the following health conditions:

- Heart trouble
- Stroke
- Diabetes
- Digestive problems (such as ulcer, colitis, or gallbladder disease)
- Asthma, emphysema, or chronic bronchitis
- Arthritis or rheumatism
- Liver problems (such as cirrhosis)
- Kidney disease
- Cancer diagnosed in the past 3 years
- Other (please specify)_____

64. In the past month, how much has your eyesight interfered with your life in general?

- a) Not at all
- b) A little
- c) A fair amount

65. In the past month, how much has your hearing interfered with your life in general?

- a) Not at all
- b) A little
- c) A fair amount

66. Please indicate if you need help from others with any of the following:

	Yes	No
Eating	•	•
Dressing	•	•
Transferring (e.g. bed to chair)	•	•
Toileting	•	•
Bathing	•	•

67. Please indicate if you need help with any of the following instrumental activities of daily living?

	Yes	No
Shopping	•	•
Taking Medications	•	•
Using the Telephone	•	•
Financing	•	•
Transportation	•	•
Preparing Meals	•	•
Doing Light Housework	•	•
Doing Laundry	•	•