Integrating Physical Activity in Primary Care Practice

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ABSTRACT

Based on a collaborative symposium in 2014 hosted by the Society of Behavioral Medicine (SBM) and the American College of Sports Medicine (ACSM), this paper presents a model for physical activity counseling for primary care physicians (PCPs). Most US adults do not meet national recommendations for physical activity levels. Socioecological factors drive differences in physical activity levels by geography, sex, age, and racial/ethnic group. The recent Patient Protection and Affordable Care Act incentivizes PCPs to offer patients physical activity counseling. However, PCPs have reported socioecological barriers to physical activity counseling and also patient barriers to physical activity, spanning from the individual to the environmental (eg, lack of safe spaces for physical activity), policy (eg, reimbursement policies), and organizational (eg, electronic medical record protocols, worksite norms/policies) levels. The aims of this paper are to: 1) discuss barriers to PCP counseling for physical activity; 2) provide evidence-based strategies and techniques to help PCPs address these counseling barriers; and 3) suggest practical steps for PCPs to counsel patients on physical activity using strategies and supports from policy, the primary care team, and other support networks.

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About half (49.6%) of US adults met the most recent (2008) Centers for Disease Control and Prevention’s Physical Activity Guidelines of at least 150 minutes weekly of moderate- or vigorous-intensity aerobic physical activity.1 Even fewer adults met the recommendations for strength training activities on 2 or more days of the week (23.6% in 2012), and fewer still fulfilled both recommendations (20.3% in 2012). Disparities in physical activity exist by socioecologic levels (ie, individual, social, and environmental levels of influence on behavior), including geography, sex, age, and racial/ethnic group. Physical activity rates are disproportionately lower among rural vs urban residents, residents of the southwestern region of the US vs other regions, women vs men, older vs younger, and racial and ethnic minorities vs non-Hispanic whites.2,3 These disparities in physical activity underscore the importance of incorporating patient socioecologic contexts, including their families, work, health care systems, and neighborhoods, in physical activity counseling.3,4

The recent Patient Protection and Affordable Care Act (ACA) has incentivized physical activity counseling by
primary care physicians (PCPs). Physical activity can be promoted at multiple levels as described above. Given the inherent trust that patients have in their PCPs, the PCP can play a central role in delivering effective physical activity interventions. In 2015, an editorial by Berra et al reiterated the overall message from a 2004 editorial by Blair and Church, which declared, “... Just as weight is addressed in some manner at nearly every physician visit, so should attention be given to recommending the accumulation of 30 minutes a day of moderate-intensity physical activity at least 5 days of the week.” This paper will assist the role of PCPs in taking advantage of recent ACA incentives to promote physical activity by providing a step-by-step guide to physical activity counseling that addresses socioecological barriers to the uptake of regular and sustained physical activity and leverages community resources that promote and support physical activity.

Despite evidence for the cost-effectiveness of physical activity counseling in primary care, only one-third of patients report the receipt of physical activity counseling by their PCPs. PCPs face many barriers to counseling their patients on physical activity, primarily due to time limitations, especially when trying to address multiple or complex medical issues. PCPs address an average of 3 medical issues per patient visit, with slightly higher averages for elderly and diabetic patients. However, PCPs are in a unique position to provide physical activity counseling because of their ability to reach a large segment of the overall population, their role as a trusted source of health information, and the range of other health professionals available within clinics.

A multilevel socioecologic approach to physical activity counseling can be centered in the primary care setting, as the PCP could provide a “prescription” (or brief advice) for physical activity to help ready the patient for making changes in their current levels or type of physical activity. The socioecologic approach can be integrated with the well-known physical activity counseling approach using the 5As—assess, advise, agree, assist, and arrange—a mnemonic that describes a sequence of counseling behaviors that are meant to engage the patient in developing a specific, safe, and realistic action plan for behavior change. The 5As have been used with success for tobacco cessation.

Further, some evidence suggests that physical activity counseling is more effective when delivered by trained counselors, to whom the provider could refer. The PCP’s time is also used more efficiently by connecting to resources within the practice, particularly among fellow primary care team members. This approach, combined with basic self-monitoring (eg, wearable tracking devices or paper journals), community resources, and follow-up with the PCP, can enhance motivation and increase self-awareness. External resources like these may be more likely to be accepted if they are suggested by the PCP, because patients tend to trust their PCPs the most for health information. PCPs lack a practical approach to overcoming barriers to physical activity counseling, which may be available by leveraging clinical and community resources. The aims of this paper are to: 1) discuss barriers to PCP counseling for physical activity; 2) provide a multilevel approach using evidence-based strategies and techniques to help PCPs address counseling barriers; and 3) suggest practical steps for PCPs to counsel patients on physical activity.

**EVIDENCE FOR THE EFFECTIVENESS OF PHYSICAL ACTIVITY INTERVENTIONS IN PRIMARY CARE**

Findings on the impact of physical activity interventions in primary care have been mixed, due to insufficient follow-up or a lack of clarity about intervention intensity. Heath et al (2012) examined systematic reviews of evidence-based physical activity interventions, which found that more effective interventions addressed multiple levels of change, including the individual, social, and environmental levels. Given the power of a PCP’s prescription for physical activity, and the importance of multiple levels of supportive resources, the integration of a multilevel approach to physical activity counseling within primary care has the potential to favorably impact patient physical activity levels.

**BARRIERS TO IMPLEMENTING PHYSICAL ACTIVITY COUNSELING IN PRIMARY CARE**

PCPs face significant challenges to physical activity counseling. Major provider barriers to physical activity counseling include limited time, skills, reimbursement, reach, and routine screening for physical activity.

**Lack of Provider Time**

One of the primary barriers to physical activity counseling in primary practice is the lack of adequate time to effectively counsel patients. Patient visits are typically brief and often cover multiple health concerns. A recent study on the effectiveness of using the 5As for physical activity counseling reported a minimal impact on the overall length of visits (83% spent <5 to 6 minutes on physical activity counseling). Further, the combination of initial brief counseling with the physician can be enhanced by referrals to other resources, as discussed in a later section, because
effective physical activity counseling requires regular follow-up visits or contacts.10

**Lack of Provider Skills**

PCPs often lack the training and skills to provide effective physical activity counseling.10,27 A recent study estimated that only 10 medical school programs provide training on physical activity, although program content is unstandardized.9 Because patients tend to place the most trust in health information from their PCPs, and a PCP prescription for physical activity has been found effective in increasing patient exercise, PCPs initiating the conversation with patients may have great impact on their physical activity levels.18

**Cost/Lack of Provider Reimbursement**

Despite the recent recommendation by the US Preventive Services Task Force for routine obesity screening, reimbursement still poses a significant obstacle to routine primary care screening and counseling for obesity, of which physical inactivity is a major contributor. Although the Centers for Medicare and Medicaid Services now offers coverage for obesity counseling, it must be provided on-site and by high-level primary care providers (ie, physicians, nurse practitioners, or physician assistants). This coverage excludes services provided by other trained health care professionals as well as services provided by phone or in a community setting. This exclusion applies despite evidence that patients have improved their physical activity levels with trained nonphysician providers, sometimes with even greater results.10,20-22 The lack of reimbursement for physical activity counseling for nonobese patients who are not necessarily seeking weight loss is a further challenge because physical activity is important regardless of weight status. Due to some ongoing challenges with reimbursement, it may be cost-effective to incorporate community referrals and other resources to supplement provider counseling.5,29

**Lack of Provider Reach to At-Risk Patients**

Primary care practices are considered an ideal location for preventive services such as physical activity counseling because of the provider’s ability to potentially reach broad segments of the population through patient visits. With Accountable Care Organizations, providers are responsible for a panel of patients, both those seen in the office and those not. By integrating community resources into primary care physical activity counseling, providers are able to also potentially reach individuals who do not regularly seek primary care.

**Lack of Routine Patient Screening for Physical Activity in Primary Care Practices**

Physical activity screening is the first part of physical activity counseling, so incorporating routine physical activity screening in primary care would create an opportunity for PCPs to provide physical activity counseling. Moreover, the routinization of physical activity screening will help patients to then see how physical activity is an important indicator of health. The National Physical Activity Plan supports prioritizing the addition of physical activity as a vital sign, but routine physical activity screening is rare in actual practice.30,31 Only a few organizations, such as Kaiser Permanente, currently screen all patients for their participation in physical activity.32 The first A of the 5As counseling framework incorporates regular physical activity screening and charting, alongside the other vitals during the same office visit.

**PATIENT BARRIERS TO PHYSICAL ACTIVITY**

Counseling patients about physical activity may reveal a number of barriers to physical activity, including limited time, fatigue, family obligations (especially for caregivers), or other competing priorities.33 They may be hesitant to try to increase their physical activity if they think that it will be too much of a time commitment,34,35 if they lack safe paths or open spaces for activity away from traffic or gangs,36 or if gyms are too far to get to or costly.12 Patients may also find it difficult to be active if they live in areas where they don’t see others being active, feel self-conscious about being active, or do not enjoy physical activities alone.33,35 The following section describes resources to help address each of these patient barriers to physical activity.

**MULTILEVEL APPROACHES TO OVERCOME BARRIERS TO PHYSICAL ACTIVITY AND PHYSICAL ACTIVITY COUNSELING**

Interventions at multiple levels of the socioecological framework can help to overcome many of the barriers described above, namely provider time and training. The PCP and the primary care team can serve as the hub for physical activity counseling, while resources at other levels (eg, policy, organizations, community) can help patients to enact and sustain changes in physical activity. The following sections describe how providers might utilize these different resources (Table) as well as how they might be incorporated into counseling (Figure).

**Primary Care Practice Organizations**

Within primary care practices, physical activity screening is the simplest way to begin a conversation about the importance of physical activity (regardless of weight status) by asking patients about their current physical activity levels. This is especially beneficial to providers who may not otherwise be comfortable initiating this conversation with the patient. Additionally, standardizing the inclusion of physical activity screening with each visit can help to emphasize the important relationship between physical activity and health for patients. The MOHR (My Own Health...
PCPs may also want to discuss physical activity monitoring with patients, especially given the growing popularity of, and advances in, wearable technology. Self-monitoring can help patients to assess their current level of physical activity and facilitate goal setting to increase their levels of physical activity. Physical activity self-monitoring tools range from basic pedometers to smartphone apps to wearable devices that can also monitor sleep and heart rate.

A reported 82% of Americans have a cell phone, which provides multiple opportunities to communicate with others about physical activity, search for medical advice, and monitor personal health information. This can reduce the amount of face-to-face time required for patient monitoring and facilitate patient—provider communication about physical activity. These devices also provide immediate feedback about patients’ physical activity levels, supporting their self-regulation of their physical activity behaviors, and can also connect patients to online communities for support.

Support Systems of Families, Friends, and Co-Workers and Others

As part of the physical activity counseling, the PCP can ask about the patient’s support system and how that might impact any new physical activity habits. This support system (eg, family, friends, co-workers, and others) might be supportive of new physical activity habits (eg, joining the patient in new activities, providing childcare to give the patient time for exercise) or discouraging (eg, complaining about physical activity takes away from family time). For individuals without a local support system or with unsupportive friends and family, virtual support groups available through fitness Web sites, apps, and forums are increasingly popular. These support systems enable the patient and his/her support to challenge and motivate each other to make and adhere to physical activity-related goals.

Local Community Resources

PCPs can identify relevant community resources for their patients via their local health department, local health-focused community organizations, and campaigns from national organizations such as the American College of Sports Medicine’s global initiative Exercise is Medicine (EIM) and Kaiser Permanente’s Rx2Move. Community-wide initiatives (eg, walk-a-thons or weight loss challenges) have increased physical activity across entire communities. In addition, local parks, civic organizations, adult
schools, community colleges, or other community groups (eg, YMCAs, Silver Sneakers) may offer free or low-cost activities and classes for adults, led by community members. A primary care team member, such as a medical assistant, may be interested in compiling local resources for providers to then refer patients. Community resources capitalize on existing social networks to support individual health behavior changes and may also address unique patient barriers, such as the need for safe spaces or child care. Provider endorsements can help to lend legitimacy to these programs to increase patient uptake.

Worksites
PCPs may also suggest that patients use physical activity resources provided at work. Adults in the US now spend a large portion of their time at the workplace, so workplace interventions may reduce time- or location-based barriers to increasing daily physical activity. Workplace resources may include: standing or treadmill desks, walking meetings, brief activity breaks during long meetings, walking during lunch breaks, workplace-sponsored activity classes (eg, yoga), and prompts to use the stairs instead of the elevator. Some workplaces may allow extended lunch breaks, flexible work hours, or discounted gym memberships in order to facilitate their employees’ abilities to exercise prior to, during, or after work without adding extra transit time or expenses associated with off-site gym memberships.

National Health Care Organizations
As mentioned earlier, EIM promotes a standardized approach to systematically assess and prescribe physical activity to patients. Early EIM pilot work has indicated that physical activity screening is best used when integrated into the electronic medical records system as a required response (G.W. Heath, unpublished data, 2014). In the US, anecdotal evidence suggests that EIM-involved PCPs have other team members assess patient physical activity, while PCPs in countries with longer office visits tend to assess the

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### Figure

How to use the 5As in physical activity counseling.

<table>
<thead>
<tr>
<th>Assess</th>
<th>Physical activity level</th>
<th>Physical abilities</th>
<th>Beliefs and knowledge</th>
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<tr>
<td>Advise</td>
<td>Health risks</td>
<td>Benefits of change</td>
<td>Appropriate “dose” of physical activity</td>
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<td>Agree</td>
<td>Co-develop personalized action plan</td>
<td>Set specific physical activity goals based on interests and confidence level</td>
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<tr>
<td>Assist</td>
<td>Identify barriers and create strategies to address them</td>
<td>Identify resources for physical activity and social support</td>
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<tr>
<td>Arrange</td>
<td>Specify plan for follow-up (e.g., visits, phone calls, text messages)</td>
<td>Check on progress/maintenance of physical activity change</td>
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patients themselves. EIM has provided credentialed exercise professionals for community referrals, which could contribute to standard, higher-quality physical activity care.

**Health Policies**

Policy-based interventions can support PCP efforts to counsel patients about physical activity. For example, the ACA requires employer-sponsored group health plans and private health insurance policies to cover preventive health services without cost sharing. On a national level, Michelle Obama and the Partnership for a Healthier America have established Let’s Move! to promote physical activity among children and their caregivers, which has led to branded physical activity challenges and informational videos that are easily accessible and shared through social media (eg, YouTube).

**PCP APPROACH TO MULTILEVEL PHYSICAL ACTIVITY COUNSELING USING THE 5AS**

We have described various multilevel strategies and supports for patients to increase their physical activity. The PCP is key to this multilevel approach, using the 5As to guide the conversation from the initial assessment of current physical activity levels through arranging follow-ups to assess physical activity (see the Figure for sample dialogue). Studies indicate that most counseling sessions focus on the first 2 As (assess physical activity levels, advise about increasing physical activity) while not addressing the last 3 As (agree on physical activity goals, assist with connecting patients with physical activity resources, arrange for follow-ups about physical activity). This finding has been attributable primarily to the PCP and organizational barriers previously mentioned. The multilevel approach to physical activity counseling as described in this paper could help to reduce these barriers (Table).

**DISCUSSION AND CONCLUSIONS**

Despite the numerous barriers that patients face with increasing physical activity, and providers face with counseling patients about physical activity, taking a multilevel approach can help increase supports for routinizing physical activity among patients. The Centers for Medicare and Medicaid Services now provides some reimbursement for on-site physical activity counseling by physicians and other high-level providers. With system-wide structural supports, such as electronic medical records or routine physical activity screening, discussions about physical activity will be more easily integrated into patient visits. With increased PCP awareness of community resources for physical activity, patients can be referred to widely available exercise classes and support groups that are low cost for both patients and provider organizations. Worksites may provide wellness programs, social support for physical activity, and opportunities for physical activity throughout the day. Primary care teams can work together to integrate physical activity into routine care at the initial and follow-up visits. Patient supports, such as the use of self-monitoring devices or community resources, can help guide the patient—provider conversations about physical activity and how patients can increase their physical activity with the support of their family/friends and co-workers.

The PCP plays a central role in this multilevel approach to physical activity counseling, from helping patients to understand the importance of physical activity to connecting them with various resources for physical activity. Using the range of supports for physical activity available at each of these socioecological levels can help to increase physical activity counseling in primary care, increase physical activity by patients, and sustain these positive behaviors.

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**References**


