

## APPENDIX

### Questionnaire

**Please answer the following items with respect to your practice. Please circle your response(s) for each item:**

As you answer, please keep in mind that exercise prescriptions are defined, like all prescriptions are, as having a type and dose, dosing frequency, a duration of treatment as a therapeutic goal, anticipated adverse effect, and written as a script.

Exercise counseling is defined as asking and informally and orally recommending exercise that may or may not include type and dose.

		Disagree Strongly	Disagree Slightly	Neutral	Agree Slightly	Agree Strongly
	Please state the level to which you agree or disagree with the following statements (PLEASE CIRCLE ONE for each statement):					
1	Exercise is beneficial in preventing chronic diseases.	1	2	3	4	5
2	Exercise can yield benefits for individuals of any age.	1	2	3	4	5
3	Exercise is beneficial in improving mental health.	1	2	3	4	5
4	Exercise has additional benefits if preformed outdoors.	1	2	3	4	5
	<b><u>Provider role:</u></b>					
5	Ascertaining information on preventive health behaviors, including exercise, is an important part of patient history-taking.	1	2	3	4	5
6	Practitioners should be proactive in prescribing exercise for all patients.	1	2	3	4	5

7	There should be required education and certification for providers to deliver exercise prescriptions.	1	2	3	4	5					
8	Providers should advocate for policies that support exercise prescriptions.	1	2	3	4	5					
9	Exercise <u>counseling</u> is stressed in your practice.	1	2	3	4	5					
10	Exercise <u>prescription</u> is stressed in your practice.	1	2	3	4	5					
11	What percentage of patients do you believe would increase their exercise levels if you were to counsel about or prescribe exercise?	1 1- 20%	2 21- 40%	3 41- 60%	4 61- 80%	5 81- 100%					
12	On a scale of 1-10, how likely are you to advocate for exercise Clinical Practice Guidelines? (Circle ONE response)	1	2	3	4	5	6	7	8	9	10

**Exercise Perspectives:**

13	The US Physical Activity Guidelines recommend that adults get how many minutes of moderate physical activity per week? (Circle ONE response)	-----Minutes-----				
		60	90	120	300	
14	The US Physical Activity Guidelines recommend that adults engage in bone and muscle strengthening activities at least how many times per week? (Circle ONE response))	1	2	3	4+	
15	Please CHECK ALL exercise initiatives you are aware of					
	<input type="checkbox"/> Personal Health Investment Today Act	<input type="checkbox"/> Exercise as a Vital Sign				
	<input type="checkbox"/> Workplace Health Improvement Program Act	<input type="checkbox"/> Moving Outdoor in Nature Act				
	<input type="checkbox"/> Physical Inactivity as a Disease	<input type="checkbox"/> Exercise is Medicine				
	<input type="checkbox"/> Place as a Vital Sign	<input type="checkbox"/> Other _____				

<b>16</b>	On a scale of 1-10, ('1' being not knowledgeable and '10' being extremely knowledgeable) how would you rate your knowledge in regard to exercise prescriptions?	1	2	3	4	5	6	7	8	9	10
<b>17</b>	On a scale of 1-10, ('1' being not confident and '10' being extremely confident) how would you rate your confidence in regards to writing exercise prescriptions?	1	2	3	4	5	6	7	8	9	10

**Exercise prescription practices:**

<b>18</b>	Do you ask/inquire about the exercise behaviors of your patients? <b>If no, skip to #22 (next page)</b>							Yes	No	
<b>19</b>	If yes, with which percent of patients do you inquire? (Circle ONE response)	1 1- 20%	2 21- 40%	3 4- 60%	4 61- 80%	5 81- 100%				
<b>20</b>	If yes, with what target group(s) of patients do you ask/inquire about physical activity/exercise? (CHECK ALL THAT APPLY)									
	<input type="checkbox"/> All patients	<input type="checkbox"/> Diagnosed with diabetes								
	<input type="checkbox"/> At risk for diabetes	<input type="checkbox"/> Diagnosed with heart disease								
	<input type="checkbox"/> At risk for heart disease	<input type="checkbox"/> Diagnosed with high blood pressure								
	<input type="checkbox"/> At risk for high blood pressure	<input type="checkbox"/> Diagnosed with cancer								
	<input type="checkbox"/> At risk for cancer	<input type="checkbox"/> Diagnosed with mental illness								
	<input type="checkbox"/> At risk for mental illness	<input type="checkbox"/> Other _____								
<b>21</b>	If yes, what motivates you to ask/inquire about exercise? (CHECK ALL THAT APPLY)									
	<input type="checkbox"/> Importance to health	<input type="checkbox"/> Quality Incentives			<input type="checkbox"/> Other					
	<input type="checkbox"/> A program that you refer patients to called _____									
<b>22</b>	Do you use electronic medical records (EMR) in your practice? (CIRCLE ONE) <b>If no, skip to #24</b>							Yes	No	
<b>23</b>	Does your EMR include a prompt to document exercise levels? (CIRCLE ONE)							Yes	No	
<b>24</b>	Do you document exercise of your patients? (CIRCLE ONE) <b>If no, skip to #28</b>							Yes	No	

25 If yes, what percentage of patients have you documented information on exercise? (CIRCLE ONE)

1	2	3	4	5
1-20%	21-40%	41-60%	61-80%	81-100%

26 If yes, with which target group(s) of patients do you record exercise? (CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> All patients                    | <input type="checkbox"/> Diagnosed with diabetes            |
| <input type="checkbox"/> At risk for diabetes            | <input type="checkbox"/> Diagnosed with heart disease       |
| <input type="checkbox"/> At risk for heart disease       | <input type="checkbox"/> Diagnosed with high blood pressure |
| <input type="checkbox"/> At risk for high blood pressure | <input type="checkbox"/> Diagnosed with cancer              |
| <input type="checkbox"/> At risk for cancer              | <input type="checkbox"/> Diagnosed with mental illness      |
| <input type="checkbox"/> At risk for mental illness      | <input type="checkbox"/> Other _____                        |

27 If yes, what motivates you to record physical activity/exercise for the patients you indicated? (CHECK ALL THAT APPLY)

- |   |   |
|---|---|
| <input type="checkbox"/> Importance to health                 | <input type="checkbox"/> Quality Incentives |
| <input type="checkbox"/> A program that you refer patients to | <input type="checkbox"/> Other _____        |

28 Which measures do you use to assess exercise levels of your patients? (CHECK ALL THAT APPLY)  
**If none, skip to #33 (next page)**

- |   |   |                               |
|---|---|-------------------------------|
| <input type="checkbox"/> Physical fitness level | <input type="checkbox"/> Activity level | <input type="checkbox"/> None |
|---|---|-------------------------------|

29 If any, what percentage of patients do you assess? (CIRCLE ONE)

1	2	3	4	5
1-20%	21-40%	41-60%	61-80%	81-100%

30 If any, what measure(s) of fitness assessment do you use? (CHECK ALL THAT APPLY)

- |   |  |
|---|--|
| <input type="checkbox"/> Resting heart rate (Step test) | <input type="checkbox"/> Number of push-ups or sit-ups |
| <input type="checkbox"/> Body Composition               | <input type="checkbox"/> BMI                           |
| <input type="checkbox"/> Something else _____           |  |

31 If yes, what measure(s) of activity assessment do you use? (CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> Steps/day               | <input type="checkbox"/> Perceived levels of exertion               |
| <input type="checkbox"/> Activity monitor/device | <input type="checkbox"/> Minutes of activity per day/week           |
| Which device? _____                              | <input type="checkbox"/> Specific activity (walking, cycling, etc.) |
| <input type="checkbox"/> Something else _____    |   |

**32** If yes, with which target group(s) of patients do you assess physical activity/exercise?  
(CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> All patients                    | <input type="checkbox"/> Diagnosed with diabetes            |
| <input type="checkbox"/> At risk for diabetes            | <input type="checkbox"/> Diagnosed with heart disease       |
| <input type="checkbox"/> At risk for heart disease       | <input type="checkbox"/> Diagnosed with high blood pressure |
| <input type="checkbox"/> At risk for high blood pressure | <input type="checkbox"/> Diagnosed with cancer              |
| <input type="checkbox"/> At risk for cancer              | <input type="checkbox"/> Diagnosed with mental illness      |
| <input type="checkbox"/> At risk for mental illness      | <input type="checkbox"/> Other _____                        |

**33** Do you refer your patients to other professionals for fitness assessment and/or prescription? (CIRCLE ONE) **If no, skip to #37**

	Yes	No
--	-----	----

**34** If yes, what percentage of patients do you refer?

	1	2	3	4	5
	1-	21-	41-	61-	81-
	20%	40%	60%	80%	100%

**35** If yes, with which target group(s) of patients do you refer?  
(CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> All patients                    | <input type="checkbox"/> Diagnosed with diabetes            |
| <input type="checkbox"/> At risk for diabetes            | <input type="checkbox"/> Diagnosed with heart disease       |
| <input type="checkbox"/> At risk for heart disease       | <input type="checkbox"/> Diagnosed with high blood pressure |
| <input type="checkbox"/> At risk for high blood pressure | <input type="checkbox"/> Diagnosed with cancer              |
| <input type="checkbox"/> At risk for cancer              | <input type="checkbox"/> Diagnosed with mental illness      |
| <input type="checkbox"/> At risk for mental illness      | <input type="checkbox"/> Other _____                        |

**36** If yes, to which types of fitness professionals do you refer, for the purpose of physical fitness assessment or prescription? (CHECK ALL THAT APPLY)

- Physiotherapist
- Chiropractors
- Exercise Physiologist
- Personal Trainer
- Kinesiologists
- Other(s) \_\_\_\_\_

**37** Do you refer your patients to specific locations to engage in exercise?

	Yes	No
--	-----	----

**If no, skip to #41**

**38** If yes, what percentage of patients do you refer to a location?

	1	2	3	4	5
	1-	21-	41-	60-	81-
	20%	40%	60%	80%	100%

**39** If yes, with what target group(s) of patients do you refer to specific locations?  
(CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> All patients                    | <input type="checkbox"/> Diagnosed with diabetes            |
| <input type="checkbox"/> At risk for diabetes            | <input type="checkbox"/> Diagnosed with heart disease       |
| <input type="checkbox"/> At risk for heart disease       | <input type="checkbox"/> Diagnosed with high blood pressure |
| <input type="checkbox"/> At risk for high blood pressure | <input type="checkbox"/> Diagnosed with cancer              |
| <input type="checkbox"/> At risk for cancer              | <input type="checkbox"/> Diagnosed with mental illness      |
| <input type="checkbox"/> At risk for mental illness      | <input type="checkbox"/> Other _____                        |

**40** If yes, to which types of locations do you refer, for the purpose of physical activity or exercise? (CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> Hospital-owned fitness facility                           | <input type="checkbox"/> Community-based center |
| <input type="checkbox"/> Walking or cycling to work/school                         | <input type="checkbox"/> Park or trails         |
| <input type="checkbox"/> Patient home, neighborhood, or worksite (videos, walking) |   |
| <input type="checkbox"/> Other(s) _____  |   |

**41** What would increase your number of referrals OR your likelihood of referring patients to a hospital-owned fitness facility (HOFF) (RANK IN ORDER OF IMPORTANCE, 1-6, 1 most important, 6 least important)

- |                                      |  |
|--------------------------------------|--|
| ___ Informational materials          | ___ Your increased planning /approving |
| ___ Increased insurance coverage     | ___ Incentive schemes                  |
| ___ Increased training of HOFF staff | ___ Something else _____               |

**42** If you DO NOT refer to hospital-owned fitness facilities (HOFF) (CHECK ALL THAT APPLY)

- |  |   |
|--|---|
| <input type="checkbox"/> Do not have a HOFF                        | <input type="checkbox"/> Patient safety concern |
| <input type="checkbox"/> You are unaware of specific HOFF programs | <input type="checkbox"/> Something else         |

**43** If you DO refer to hospital-owned fitness facilities, does your organization have a referral program?  
(CHECK ONE)

- Yes  No
- Name of program: \_\_\_\_\_

**44** What would increase your number of referrals OR your likelihood of referring patients to parks/trails to exercise (CHECK ALL THAT APPLY)

- Park/trail informational materials (such as maps via handouts or websites)
- Increased medical supervision at park/trail
- Increased security (police)
- Increased park/trail quality
- Something else \_\_\_\_\_

**45** Exercise prescriptions are defined, like all prescriptions are, as having a type and dose, dosing frequency, a duration of treatment as a therapeutic goal, anticipated adverse effect, and written as a script.

Do you provide written physical activity/exercise prescriptions, as defined above, to your patients? (CHECK ONE)

Yes

No (Skip to question #48)

**46** If yes, to what percent of patients do you give written physical activity prescriptions?

	1	2	3	4	5
	1-	21-	41-	61-	81-
	20%	40%	60%	80%	100%

**47** If yes, with what target group(s) of patients do you give exercise prescriptions? (CHECK ALL THAT APPLY)

All patients

At risk for diabetes

At risk for heart disease

At risk for high blood pressure

At risk for cancer

At risk for mental illness

Diagnosed with diabetes

Diagnosed with heart disease

Diagnosed with high blood pressure

Diagnosed with cancer

Diagnosed with mental illness

Other \_\_\_\_\_

### **Barriers to Exercise Prescription**

Circle a number for each item below.

How important do you perceive the following barriers to be that might prevent you from prescribing exercise (more) regularly?

**Disagree Strongly**     **Disagree Slightly**     **Neutral**     **Agree Slightly**     **Agree Strongly**

**48** I do not have enough patient visit time     1     2     3     4     5

**49** Patients' lack of time     1     2     3     4     5

**50** Patients' lack of motivation/interest to change     1     2     3     4     5

**51** Lack of standard guidelines on exercise counselling and prescription     1     2     3     4     5

**52** Patients prefer pharmaceutical interventions     1     2     3     4     5

**53** Lack of process in place for me to follow     1     2     3     4     5

**54** Lack of evidence for health benefits of physical activity     1     2     3     4     5

55	I do not have enough reimbursement/ financial incentive	1	2	3	4	5
56	Lack of exercise education in medical school and residency	1	2	3	4	5
57	Lack of continuing education in physical activity	1	2	3	4	5
58	I need more personal knowledge	1	2	3	4	5
59	Other lifestyle changes are more important	1	2	3	4	5
60	Lack of safe locations to refer patients	1	2	3	4	5
61	Lack of affordable locations to refer patients	1	2	3	4	5
62	Lack of referral proximate to the patients in treatment	1	2	3	4	5
63	Lack of patients' cultural acceptance of physical activity/exercise prescriptions	1	2	3	4	5
64	Weight loss as the main focus of physical activity/exercise physical activity/exercise discourages patients	1	2	3	4	5
65	List other barriers you deem important: _____ _____					

**Continuing education needs  
assessment**

- 66 Have you received formal training about how to prescribe exercise? (CIRCE ONE) If yes, please include from which organization or institution you received the training.
- Yes, \_\_\_\_\_ No
- 67 What organization(s) do you earn your continuing education through? (CHECK ALL that apply)
- AAFP  ACP  
 AANP  Other \_\_\_\_\_



**68** Topics of interest for more training in relation to exercise that would be useful (CHECK ALL that are of interest)

- Exercise prescription relative to specific medical conditions
- Exercise prescription relative to age
- Exercise prescription relative to specific medications
- Locations to refer patients
- Other \_\_\_\_\_

**69** Training format (Rank in order of preference, 1 most preferred, 5 least preferred.)

- \_\_\_ Face-to-face seminar/conference
- \_\_\_ Video/DVD
- \_\_\_ Printed self-study guide
- \_\_\_ Online/internet training
- \_\_\_ Something else \_\_\_\_\_

**70** Materials to share/administer to patients (Rank in order of preference, 1 most preferred, 5 least preferred.)

- \_\_\_ Poster-based guidelines for wall
- \_\_\_ Prescription pad for exercise
- \_\_\_ Video
- \_\_\_ Online/internet
- \_\_\_ Phone/tablet application
- \_\_\_ Something else \_\_\_\_\_

These questions are about your physical activity.

### **International Physical Activity Questionnaire – Short Form**

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time

**71** During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

- \_\_\_ **days per week**       No vigorous physical activities.  
**If none, Skip to question 73**

- 72 How much time did you usually spend doing vigorous physical activities on one of those days?

\_\_\_\_\_ hours per day      \_\_\_\_\_ minutes per day       Don't know/Not sure

- 73 Think about all the moderate activities that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

\_\_\_\_\_ days per week       No moderate physical activities.

**If none, Skip to question 75**

- 74 How much time did you usually spend doing moderate physical activities on one of those days?

\_\_\_\_\_ hours per day      \_\_\_\_\_ minutes per day       Don't know/Not sure

- 75 Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

During the last 7 days, on how many days did you walk for at least 10 minutes at a time?

\_\_\_\_\_ days per week       No walking. **If none, Skip to question 77**

- 76 How much time did you usually spend walking on one of those days?

\_\_\_\_\_ hours per day      \_\_\_\_\_ minutes per day       Don't know/Not sure

- 77 The last question is about the time you spent sitting on weekdays during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

During the last 7 days, how much time did you spend sitting on a week day?

\_\_\_\_\_ hours per day      \_\_\_\_\_ minutes per day       Don't know/Not sure

**Demographic information:**

78 With which gender do you identify? (CHECK ONE)

- Male  Female

79 What is your ethnic/racial background? (CHECK ALL THAT APPLY)

- White  Black or African American  
 Native American or American Indian  Asian / Pacific Islander  
 Choose not to answer  Hispanic or Latino

80 What is your age? \_\_\_\_\_

81 What is your specialty/role? (CIRCLE ONE)

- Family Medicine  Internal Medicine  Nurse Practitioner  
 Other \_\_\_\_\_

82 Are you currently a final year resident? (CIRCLE ONE) Yes No

83 How many years have you been practicing medicine \_\_\_\_\_ years

84 Where did you receive your exercise/physical activity medical training?

- CME  Medical School  It was not included  
 Other \_\_\_\_\_

85 What is your practice location? (CHECK ALL THAT APPLY)

- Rural  Urban  Suburban

86 What is the structure of your practice? (CHECK ONE)

- Solo practice  Group practice  Hospitalist  
 Other \_\_\_\_\_

87 Are you part of an Accountable Care Organization (ACO), wellness, or population health quality initiative? (CHECK ONE) If yes, please include the initiative.

- Yes \_\_\_\_\_  No

88 What hospital(s) do you work and/or have admitting privileges?

\_\_\_\_\_