Efficacy of Using Physical Activity Mentors to Increase the Daily Steps of Older Adults in the Primary Care Setting: A Pilot Study

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The purpose of this pilot study was to determine if using physical activity (PA) mentors has any additional impact on daily steps of older adults participating in the Maine in Motion (MIM) program in the primary care setting. Participants were randomly assigned to a MIM-only group (n = 14) or a MIM+ mentor group (n = 14). The MIM intervention lasted 6 months with follow-up at 12 months. Average age of participants was 64 ± 8.8 years and most participants had multiple chronic illnesses. At baseline, mean body mass index (BMI) was 32.2 ± 5.1 and average daily steps were 4,236 ± 2,266. Repeated-measures ANOVA revealed significant main effects for steps, \( F(2.324, 59.104) = 4.168, p = .015 \), but no main effects for group, \( F(1, 25) = 2.988, p = .096 \), or time-by-group interaction, \( F(2.324, 59.104) = 0.905, p = .151 \). All participants significantly increased daily steps over the course of the intervention, with MIM+ participants maintaining increases at follow-up. No significant findings were found for BMI.

Keywords: pedometer, walking, intervention

Despite knowledge of the many health benefits of physical activity (PA), few older adults engage in regular PA (Centers for Disease Control and Prevention, 2012; Evenson, Buchner, & Morland, 2012). For those older adults who do engage in regular PA, walking is reported by more than 50% as their primary activity (Centers for Disease Control and Prevention, 2012; Chodzko-Zajko et al., 2009). Walking is a functional activity that is readily accessible, low cost, and one in which most older adults are able to do (Centers for Disease Control and Prevention, 2012; Simpson et al., 2003). Given the familiarity older adults have with walking, the health benefits that can be achieved, and the general preference for walking as a primary mode of PA, walking-based PA interventions have been recommended for older adults (Centers for Disease Control and Prevention, 2012).

Because pedometers can objectively measure walking activity and serve as a motivational tool for wearers to walk more, the use of pedometers in PA interventions has become increasingly popular. Such interventions have been found to be effective in increasing PA levels of older adults residing in the community (Croteau, Richeson, Farmer, Jones, & Sterling, 2007; Jensen, Roy, Buchanan, & Berg, 2004; Sarkisian, Prohaska, Davis, & Weiner, 2007; Strath et al., 2011) and in those with chronic illness, including arthritis (Talbot, Gaines, Huynh, & Metter, 2003), diabetes (Engel & Lindner, 2006; Tudor-Locke et al., 2004), hyperlipidemia (Furukawa et al., 2003; Sugiura, Kaijima, Mirbod, Iwata, & Matsuoka, 2002), hypertension (Moreau et al., 2001), and obesity (Engel & Lindner, 2006; Moreau et al., 2001; Tudor-Locke et al., 2004).

With a majority of older adults visiting their primary care physician (PCP) at least annually (Hing, Chery, & Woodwell, 2006), the primary care setting has been identified as an ideal setting for the promotion of PA. PCPs have contact with many patients on a regular basis and are generally viewed as being credible sources of health information, particularly among older adults and those with multiple chronic diseases (Schofield, Croteau, & McLean, 2005). Therefore, visits to the PCP provide the opportunity for counseling on PA. However, recent population studies in New Zealand, the United States, and the United Kingdom indicate that only between 13% and 34% of patients report receiving PA advice from their PCP in the last 12 months (Croteau, Schofield, & McLean, 2006; Honda, 2004). Lack of time and expertise are commonly cited as a barrier to providing PA advice (Hébert, Caughy, & Shuval, 2012).

To address PCP-perceived barriers to PA counseling, allied health professionals, including nurses and fitness professionals, are being used to deliver PA counseling to patients. Research on the use of New Zealand’s PA scripting scheme, the Green Prescription, has demonstrated efficacy in increasing and maintaining PA in general (Elley, Kerse, Arroll, & Robinson, 2003) and with
older adults (Kerse, Elley, Robinson, & Arroll, 2005), while also demonstrating cost-effectiveness (Elley et al., 2004). More recently, in a review and meta-analysis of PA promotion trials conducted in primary care settings, Orrow, Kinmonth, Sanderson, and Sutton (2012) concluded that sedentary adults recruited in the primary care setting significantly increase PA at 12 months, as assessed via self-report.

The nonphysician delivery model for PA counseling has also included pedometer-based interventions for adults in the primary care setting (McKay et al., 2008; Stovitz, VanWormer, Center, & Bremer, 2005). Stovitz et al. (2005) used brief physician endorsement with pedometer-based program delivery and follow-up phone calls by a health educator on an adult sample in the family practice setting; participants in the pedometer arm of the intervention improved daily steps by 41% after 9 weeks. While also addressing an adult population, McKay et al. (2008) used pedometer packs delivered by GP nurses, health visitors, and physiotherapists in a 12-week walking program; step counts of patients increased by 101% following the 6-month intervention.

Recently, pedometer-based intervention studies in the primary care setting have focused on the older adult population (Armit, Brown, Ritchie, & Trost, 2005; Kolt et al., 2012). Armit et al. (2005) compared the effects of three 12-week general-practice-based strategies. While the small numbers of participants in each group limited the power to detect significant differences among the groups, the authors concluded that individualized counseling and follow-up contact with an exercise scientist, regardless of pedometer use, would be more effective in increasing PA of older adults than brief physician advice (Armit et al., 2005). Kolt et al. (2012) compared the use of pedometers to the standard counseling used in New Zealand’s Green Prescription. Using self-reported PA as a primary outcome variable, participants using pedometers had greater increases in walking behavior.

Limitations in the aforementioned studies on the use of pedometers to increase the PA of patients in the primary care setting include one or more of the following: lack of a control or comparison group, short intervention duration, use of self-report to assess PA, and lack of postintervention follow-up. In addition, there is limited research on pedometer-based PA intervention research conducted on older adults with multiple chronic illnesses in an internal medicine setting. As such, this pilot study aims to examine the influence of a pedometer-based intervention on the PA levels and other health outcomes of older adults in an internal medicine setting utilizing PCP recommendation and prescription with program delivery via exercise specialist. This study also seeks to examine the potential additional impact that monthly meetings with a fitness professional serving as a PA mentor might have on study outcomes. Therefore, two interventions will be compared: one that is a minimal-contact intervention and one with the addition of a PA mentor and monthly group meetings. Feasibility of implementation will also be explored.

Methods

Participants and Procedures

For this pilot study, a mixed methodology was used, with an experimental, repeated measures design used to determine the main outcome measures and qualitative interviews of health care providers used to explore feasibility of implementing the intervention. The participants recruited for this study were inactive adults over the age of 50 years who were patients in an internal medicine practice.

An informational meeting was held with all internal medicine practice staff, which included physicians, nurse practitioners, medical assistants, and receptionists. General information on the study was provided, including benefits of participation to patients, and logistical details (recruitment, scheduling, facility, use of prescription forms) were discussed. Flyers were placed on the walls of the waiting area and on walls in examination rooms. Study prescription forms (described later) were also placed in each examination room.

During scheduled patient visits, health care providers (physicians and nurse practitioners) identified patients who were not regularly active and for whom they felt increased PA would be appropriate and beneficial. In completing an exercise prescription form, the provider was prompted to ask, “Do you participate in moderate intensity physical activity for at least 30 minutes (total or in three 10-minute bouts) on 5 or more days of the week?” Examples of moderate intensity activities were given. If the patient answered “no” to being regularly physically active or if they had been regularly physically active for 6 months or less, they were deemed a candidate and were invited to participate in the study. Providers described the intervention to the patient and, if the patient indicated interest, completed a prescription form indicating his or her recommendation and medical clearance to participate in the program. Upon checking out of the clinic, the patient gave the prescription form to the receptionist, who then scheduled the patient for an initial meeting with a researcher.

Before the initial meeting with a researcher, participants were randomly assigned to one of two intervention groups: a pedometer-only intervention group (MIM) or a pedometer plus mentor intervention group (MIM+). See Figure 1 for a diagram of the study flow. At the initial meeting, all participants read and signed an informed consent form approved by the primary researcher’s institutional review board. Participants were selected if they met the following criteria: (a) ≥50 years of age, (b) able to ambulate independently, (c) able to walk at a velocity and/or with appropriate gait patterns necessary to permit adequate pedometer readings (as determined by pedometer walking test), (d) wear clothing that permits appropriate placement of pedometer (clothing that has a waistband), and (e) have not had a physician or nurse practitioner indicate that increased PA is harmful.
a summary of their assessments to be shared with their physician if desired. The Accusplit AE120XL electronic pedometer (an imported version of the Yamax Digi-Walker SW-200) was used to objectively assess PA in this study. Reliability and validity of various Digi-Walker models in accurately assessing daily step counts has been established with adult populations in free-living conditions (Le Masurier, Lee, & Tudor-Locke, 2004; Schneider, Crouter, & Bassett, 2004) and community-dwelling older adults (Cyarto, Myers, & Tudor-Locke, 2004). The pedometer was worn on the waist, clipped to a belt or clothing, and centered over the dominant foot. A 20-step walking test (10 steps down a hallway and 10 steps back at usual walking speed) was conducted to determine the most accurate placement on the waistline, with adjustments made if the pedometer reading was not within two steps of the actual steps counted. Pedometers were set to 0 and sealed during the baseline measurement period. Participants were instructed to wear the pedometers during all waking hours except when bathing or swimming. Seven days after issuance, pedometers were unsealed by the researchers and daily step counts were recorded. If participants failed to wear the pedometer for the full 7 days, the total step counts recorded were divided by the actual number of days the pedometer was worn. For the 3-, 6-, and 12-month measurement periods, daily step counts were determined from participants’ step calendar recordings from the previous 7 days. No participants wore the pedometer for less than 5 days during the measurement periods.

Following completion of the intervention, health care providers participating in the study were interviewed for their views on program feasibility. Feasibility questions related to patient recruitment and program delivery.

**Intervention**

The PA intervention used for all participants in this study was Maine in Motion (MIM), a program developed by the Maine Governor’s Council on Physical Activity that has been in use throughout the state of Maine since 2004. The 6-month program, based on social cognitive theory (Bandura, 1977), uses a participant manual and consists of counseling (goal-setting, activity selection, strategies for overcoming barriers), pedometer usage, and self-monitoring. Components are similar to those used in other studies on interventions based on social cognitive theory (Tudor-Locke et al., 2004) and in recent pedometer-based PA interventions utilizing self-regulation theory (McMurdo et al., 2010). Upon completion of preintervention testing, all participants met with a fitness professional for a counseling session to set daily step goals, review pedometer usage, review tips for increasing daily steps (both incidental and planned walking), brainstorm strategies for overcoming barriers, and discuss procedures for keeping a step calendar. Daily step goals were set as a percentage of the participant’s baseline steps and typically involved an increase of 5–10% over baseline. From a list of sample strategies (such as parking farther away

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**Measures**

Measures were taken at baseline and at 3, 6, and 12 months. Demographic variables (age, gender, ethnicity, employment status) and health status variables (chronic illnesses, medications) were collected at baseline. At baseline and at 3, 6, and 12 months, health measures were taken and current level of PA was assessed. Health measures included height and weight to determine body mass index (BMI), waist circumference, resting heart rate, and resting blood pressure. Participants were given...
in a parking lot, walking while waiting for an appointment, walking with a friend, taking your dog for an extra walk) and through brainstorming, participants selected strategies that they wanted to use to increase their daily PA. Participants were encouraged to select two or three strategies that they felt were achievable for them on a daily basis. Also from a list and through brainstorming, participants identified potential barriers they felt they might encounter over the course of the intervention; discussion then followed on how the participant might overcome the identified barriers.

All study participants wore their pedometer per procedures described above. They were instructed to reset the pedometer to zero at the beginning of each day, wear the pedometer during all waking hours, use strategies previously selected to increase their PA, and periodically examine the number of steps on the pedometer to determine progress toward meeting their daily goal. At the end of each day, participants were instructed to remove the pedometer and record the following on their step calendar: date, total number of steps displayed on the pedometer and, if desired, strategies used to increase PA that day. Participants were instructed on how to calculate daily step counts at the end of each week and how to determine new daily step count goals for the upcoming week.

At the 3-month and 6-month testing sessions, all participants met individually with a fitness professional to review the process for setting daily step goals, procedures for keeping the step calendar and strategies to increase and/or maintain PA. Participants in the MIM+ group attended group meetings each month with a fitness professional for the first 6 months. At the monthly meetings, participants turned in their calendars, received new calendars, determined new goals, and shared strategies used to increase PA. For the participants who could not attend each monthly group session, a phone conference was conducted and exchange of calendars occurred by mail. At the end of the study, participants identified potential barriers they felt they might encounter over the course of the intervention; discussion then followed on how the participant might overcome the identified barriers.

### Data Analysis

Independent $t$ tests were used to check for group differences before the intervention. Dependent variables included daily step count and BMI. Intent-to-treat analyses were conducted with daily step count data per procedures described by Kang, Zhu, Tudor-Locke, and Ainsworth (2005). Repeated-measures ANOVA procedures with one independent group factor (group) and four repeated measures factors (time) were used to examine changes over time and differences between the groups on the dependent variables. Statistical significance was set at $p < .05$. Data were analyzed using Statistical Package for the Social Sciences Version 19.0 (Chicago, IL).

### Results

Of the 36 study participants who completed baseline testing, 4 dropped out before completing the 3-month measures and 4 dropped out before completing the 6-month measures (22% dropout rate from baseline to 12 months), leaving a final $N$ of 28 (21 women, 7 men). The primary reason for dropout included lack of continued interest, time constraints, and injury or illness. There were no significant differences in age, gender, BMI, waist circumference, or baseline daily step counts between participants who completed the study and those who dropped out ($p > .05$).

The majority of the sample were White ($n = 27$), female ($n = 21$), employed ($n = 16$), and reported completing some college ($n = 16$). The age range was 51–81 years ($M = 64.0$, $SD = 8.8$). At baseline, there were no significant differences among the groups in terms of age, BMI, waist circumference, and daily steps (Table 1). Mean BMI for the total sample was 32.2 ($SD = 5.1$), with 27 of 28 participants having a BMI over 25 and 17 participants having a BMI of 30 or greater. Mean waist circumference was 40.3 in., with 25 participants having a waist circumference greater than 35 in. For the total sample, a majority of the participants reported having multiple chronic conditions, including hyperlipidemia ($n = 21$), hypertension ($n = 18$), osteoarthritis ($n = 15$), and Type 2 diabetes ($n = 14$), and a majority reported taking five or more prescribed medications ($n = 17$).

Table 2 and Figure 2 display the daily steps and BMI for the MIM, MIM+, and total groups at baseline and 3, 6, and 12 months. The total sample averaged 4,236 ($SD = 2266$) daily steps at baseline, with a range of 1,411–9,200 daily steps. For daily steps, significant main effects were found for time, $F(2.324, 59.104) = 4.168, p = .015$ (ES =

### Table 1 Baseline Characteristics of Participants, $M$ (SD)

<table>
<thead>
<tr>
<th>Variable</th>
<th>MIM group ($n = 14$)</th>
<th>MIM+ group ($n = 14$)</th>
<th>Total group ($n = 28$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>63.5 (8.9)</td>
<td>64.3 (8.9)</td>
<td>64.0 (8.8)</td>
</tr>
<tr>
<td>BMI</td>
<td>32.1 (5.1)</td>
<td>32.4 (5.4)</td>
<td>32.2 (5.1)</td>
</tr>
<tr>
<td>Daily steps</td>
<td>4,290 (2,111)</td>
<td>4,183 (2,489)</td>
<td>4,236 (2,266)</td>
</tr>
</tbody>
</table>

Note. MIM = minimal contact intervention; MIM+ = monthly group meetings with mentor; BMI = body-mass index.
Table 2  Daily Step and BMI Scores Among the Groups at Baseline and 3, 6, and 12 months, $M \ (SD), \ N = 28$

<table>
<thead>
<tr>
<th>Group</th>
<th>Baseline</th>
<th>3 Months</th>
<th>6 Months</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total group</td>
<td>4,236 (2,266)</td>
<td>5,495 (2,290)**</td>
<td>5,730 (2,902)**</td>
<td>5,369 (2,205)**</td>
</tr>
<tr>
<td>MIM</td>
<td>4,290 (2,111)</td>
<td>5,031 (2,258)</td>
<td>5,077 (2,709)*</td>
<td>4,902 (2,202)</td>
</tr>
<tr>
<td>MIM+</td>
<td>4,183 (2,489)</td>
<td>5,960 (2,308)**</td>
<td>6,383 (3,040)**</td>
<td>5,835 (2,186)*</td>
</tr>
<tr>
<td>Body-mass index</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>total group</td>
<td>32.2 (5.1)</td>
<td>32.5 (5.4)</td>
<td>32.4 (5.6)</td>
<td>31.6 (5.8)</td>
</tr>
<tr>
<td>MIM</td>
<td>32.1 (5.1)</td>
<td>32.4 (5.7)</td>
<td>32.9 (5.9)</td>
<td>32.0 (6.1)</td>
</tr>
<tr>
<td>MIM+</td>
<td>32.4 (5.4)</td>
<td>32.5 (5.3)</td>
<td>31.9 (5.6)</td>
<td>31.1 (5.7)</td>
</tr>
</tbody>
</table>

Note. MIM = minimal contact intervention; MIM+ = monthly group meetings with mentor; Repeated-measures ANOVA significant for time. No significant difference between delivery modes.

*p < .05, **p < .01. Significantly different from baseline.

Figure 2 — Daily step counts for both groups at baseline and 3, 6, and 12 months (i.e., 6 months postintervention). Note: MIM = minimal contact intervention, MIM+ = monthly group meetings with mentor.
and 9,000 daily steps and special populations averaged
review, adults aged 65 and older averaged between 2,000
review of 13 pedometer-based PA interventions. In that
of steps (1,411–9,200) in this study clearly fall in the
significantly greater steps over baseline at 12 months. For BMI,
there were no significant main effects for time, group, or
time by group interaction. The amount of missing data
(29–50%) for waist circumference measures warranted exclusion from the final analysis.

In terms of intervention feasibility, health care providers (n = 2) were interviewed to determine their perceptions of the recruitment and implementation process. For recruitment, providers indicated that having flyers on the walls in exam rooms and making prescription forms available facilitated their remembering to ask patients about their PA and to recommend them to the study. They felt the prescription form was easy to use and it took approximately 2–3 min to ask the patient about his or her PA and to complete the form. When they remembered to ask patients, they did ask every patient who presented for an appointment who they felt would benefit from participating in the study. Providers felt that most patients were receptive to participating in the study. As a result of participating in the study, they felt that their awareness about asking patients about PA levels in the future was increased.

In terms of implementation, providers felt that the process of completing a prescription form, having the patient present the prescription form upon checkout to the receptionist, and having the receptionist schedule the patient for the first study appointment was both time and resource efficient. Scheduling and use of the facility for data collection and monthly meetings were also acceptable to the providers. Lastly, providers noted their confidence in having fitness professionals deliver the PA intervention to their patients.

**Discussion**

The purpose of this study was to examine the effect of a pedometer-based intervention on daily step counts of older adults in an internal medicine setting and to determine if the use of mentors had any additional impact on daily steps. Findings from this study indicate that (a) participants in both interventions significantly increased their daily steps from baseline to 6 months and (b) participants in the mentor intervention continued to achieve significantly greater steps over baseline at 12 months.

The average daily steps at baseline (4,236) and range of steps (1,411–9,200) in this study clearly fall in the ranges found by Tudor-Locke et al. (2011) in a recent review of 13 pedometer-based PA interventions. In that review, adults aged 65 and older averaged between 2,000 and 9,000 daily steps and special populations averaged 1,200–8,800 daily steps. The values found in this study also fall in the range of baseline daily step values found in studies conducted on similarly aged healthy populations in the United States and Canada: 3,536 (Sarkisian et al., 2007), 3,987 (Strath, Swartz, & Cashin, 2009), 4,027 (Jensen et al., 2004), 4,963 (Croteau et al., 2007), 5,055 (Culos-Reed, Stephenson, Doyle-Baker, & Dickinson 2008), and 5,235 (Strath et al., 2011).

In the current study, both groups significantly increased their daily steps at the end of the 6-month intervention. The MIM-only group increased their daily steps by 18% (787 steps over baseline) during the intervention and maintained a daily step increase of 14% (612 steps over baseline) at 12 months (i.e., 6 months postintervention). The MIM+ group increased their daily steps by 53% (2,200 steps over baseline) during the intervention and maintained a daily step increase of 40% (1,652 steps over baseline) at 12 months (i.e., 6 months postintervention). These increases are similar to those found in a recent study conducted on older adults in the primary care setting (Mutrie et al., 2012), where participants increased daily steps by 25.2% during the 12-week intervention and maintained a 22.7% increase over baseline at 24 weeks.

In the current study, the increase in daily steps from baseline to 3 and 6 months can be partially explained by a change in seasons as in Maine and any northern climate, it would be expected that individuals would increase their PA during the summer months. What is notable in the current study however is that there was some maintenance in daily steps for both groups from one winter to the next. These findings are similar to the 10,000 Steps Ghent intervention, where less-active adults maintained an increase of 896 steps/day after 1 year (De Cocker, De Bourdeaudhuij, Brown, & Cardon, 2009). Other research findings indicate declines in daily steps at various measurement periods postintervention (Sidman, Corbin, & Le Masurier, 2004; Talbot et al., 2003).

While no statistically significant difference among the groups was found in terms of daily step change during the intervention or postintervention, the MIM+ group did maintain a significant increase in daily steps over baseline at 12 months. With a step cadence rate of approximately 100 steps/min, as described by Tudor-Locke et al. (2011), maintenance of an increase of 1,652 steps after 12 months would correspond to approximately 16.5 min of additional ambulatory activity above baseline. It could be that health benefits of at least maintaining such activity over a longer term than 6 months postintervention would become evident, particularly in chronically ill older adults. It is thus recommended that longer-term follow-up on health outcomes be included in future interventions on similar populations.

Information on program feasibility was obtained from health care providers. It seems that the recruitment process, which took no more than 3 min of providers’ time, and use of space and resources within the internal medicine office were acceptable to the providers. They cited that flyers posted in the exam rooms and prescription forms made
readily available made it easier for them to remember to ask patients about PA and to complete a prescription. This process addressed the time barrier that is frequently cited by physicians as a reason for not asking about or providing counseling on PA (Hébert, Caughy, & Shuval, 2012).

This study used fitness professionals for program delivery to address the time and PA expertise issues facing physicians. The use of allied health professionals has been shown to be effective in increasing the PA levels of participants; however, the use of fitness professionals or other health professionals may be considered resource heavy. Other options might include the use of other allied health professionals or the use of peer mentors, for which there has been previous success with older adult and chronic illness populations (Buman et al., 2011; Tudor-Locke et al., 2009).

Despite the findings of the current study, there are some limitations that warrant attention. Because this was a pilot study with limited sample size, it is recommended that future studies be conducted with larger samples. A larger sample size would better address issues of missing data and dropout and allow for comparisons among various age and chronic illness groups.

Even though health care providers identified all patients in need of participation in the study, those who signed up to participate may have been more motivated than those who did not, thus selection bias may have been present. However, there is still a greater potential to recruit from the sedentary population in a primary care or internal medicine office than from the community. Selection bias may have also been an issue with regard to the health care providers themselves volunteering to participate in the study. With any population, perhaps more so with older adults, there is the potential for the Hawthorne effect, in which participants may have had additional motivation to increase or maintain PA, knowing they would be meeting with researchers to report on such activity. However, this would have been the case with both intervention groups in this study.

A limitation with the pedometer is that it only measures ambulatory activity and either does not measure or undermeasures nonambulatory activity (e.g., cycling and swimming) so it may be useful to include step equivalents for such activities. In this study, both groups received the pedometer intervention, while the MIM+ group also met monthly in a group with a mentor. There may have been a social effect to meeting with peers that may have had an additional contribution; as with any multifaceted intervention, it is difficult to tease out the relative contribution of each of the individual components. Thus, it is recommended that future interventions focus on specific aspects of each intervention and that qualitative data (i.e., interviews, focus groups) be collected on participants to identify aspects they felt contributed most to their own increase and/or maintenance of PA.

In conclusion, both pedometer-based PA interventions in an internal medicine practice were effective in increasing the daily steps of participants while enrolled in the intervention. Using a PA mentor may help enhance the effectiveness of such interventions. Health care providers also found it feasible to recruit patients for the intervention and found the program-delivery logistics to be acceptable. Findings from this study can be used in developing future pedometer-based PA interventions for older adults delivered by fitness professionals in the internal medicine setting.

References


