The Abridged Guide to Training Active Older Adults:

Pre-Participation Screening and the Goal-Setting Process

COMING SOON

Dr. Christian Thompson

Functional Aging Summit

June 12, 2021

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Thompson Fitness Solutions

We provide tools for fitness & clinical professionals to empower their older clients to live exciting and fulfilling lives through education and innovative, challenging, and fun exercise training programs.

Our Brands & Partners

MOBILITY MATTERS

FAI FUNCTIONAL AGING INSTITUTE

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Objectives

- Identify recommended steps for gaining important health information about your older clients
- Understand when medical clearance is necessary
- Learn how to ask pertinent questions to reveal more information
- Understand 2 models of behavior change
- Learn how to utilized Motivational Interviewing to assist with behavior change

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Remember: This your PROFESSION! Protect It!!!!

- Liability is EVERYWHERE!
  - Professional, Premises, Equipment, Harassment/Abuse…etc.
- Steps to limit liability
  - Pre-Participant Health Screening
  - Medical Clearance
  - Liability Protection

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Here's What Can Happen!

$750,000 Settlement for Personal Trainer Negligence

June 1, 2015

This case was not handled by our firm. However, if you have any questions regarding this case, or any personal injury matter, please contact Joseph Maya at 203-221-3100 or by email at JMaya@MayaLaw.com.

In this negligence matter, the plaintiff alleged that the defendants, a personal trainer and fitness center, were liable for injuries sustained by the plaintiff when she was catapulted from a Bosu Ball platform, which was specifically not intended to be used in that manner. The defendants denied the allegations, and maintained that the use of the equipment came with risks.

http://www.mayalaw.com/2015/06/01/750000-settlement-for-personal-trainer-negligence/

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Pre-Participation Screening

- First Step Upon Meeting Potential Client/Patient
  - PAR-Q+ – Identifies potentially dangerous conditions that may be problematic with exercise
    - See PAR-Q+
  - Decide on Need for Medical Clearance
    - See ACSM Flow Chart
  - Medical History Form – Gain more information about other conditions/behaviors
    - See: TFS Health History

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Medical Release/Clearance

- Times They Are A Changin'!!!!
- Medical release was recommended for ALL older adults
- Data analysis - VERY FEW older adults are at significant risk & clearance generally is not necessary
  - See: 2020 ACSM Risk Chart
  - See: NSCA Physician Referral Form

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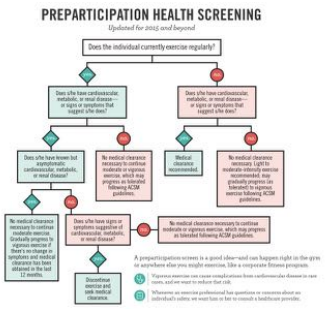

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Now… Let's Look Beyond The "Job"

- We are on a journey with our clients/patients
- We affect many aspects of their lives beyond functional improvement
  - Developing self-esteem & self-efficacy
  - Motivation and behavior change

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However…Facilitating Behavior Change is NOT Easy!

Eye-Popping Example: <10% of older adults engage in 2x/wk resistance training recommendation

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Where To Begin??

- Learn From Clinical Environments
  - Comprehensive Geriatric Assessment (CGA)
  - Multidimensional including all areas of wellness
  - Living Arrangements, Medication, Emotional Health, Injury History
- Ask Pertinent Questions
  - How well do you sleep?
  - Tell me about any pain you might have on a regular basis
- Use Behavior Models To Assist Understanding

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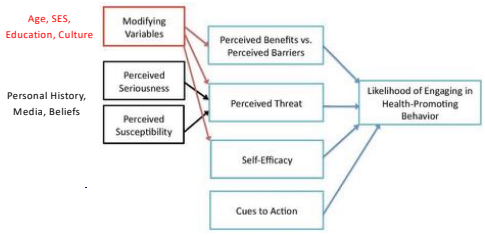
Health Behavior Model



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Transtheoretical Model
a.k.a. Stages of Change Model

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This Process Starts IMMEDIATELY!!!

- Build Rapport & Sense of Understanding
  - OAs are used to not feeling "listened to"
- Get to the "WHY" of them coming to you
- Can be facilitated by MOTIVATIONAL INTERVIEWING strategies

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Motivational Interviewing

- Began with substance abuse treatment in 1980s
- Goal is to arrive at the "WHY"
- Primary Characteristics
  - Client Centered (Client Driven)
  - Enhances INTRINSIC motivation

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Motivational Interviewing – How To Do It

- Professional GUIDES the Conversation
  - Explores the person's point of view
  - Encourages "change talk"
  - Steers away from "barrier talk"

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Motivational Interviewing Core Skills

- O – Open Ended Questions (Why)
- A – Affirmations (Good Job)
- R – Reflections (What I Heard)
- S – Summary

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Motivational Interviewing Resources to Utilize

- Decisional Balance Sheet

- Goal Attainment Importance & Confidence Scales

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Decisional Balance Sheet

	Disadvantages	Advantages
No Change		
Change		

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Decisional Balance Sheet

	Disadvantages	Advantages
No Change	FEARS Show Solutions!	HABITS Focus on Change!
Change	EXCUSES Problem Solve!	ASPIRATIONS Focus On The WHY!

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Importance & Confidence Scales

- Measures MOTIVATION and SELF-EFFICACY
  - How Important (WHY) & How Confident (HOW)?
- Generates "Change Talk"
  - Why is it a A instead of B? (WHY)
  - What would it take to go from X to Y? (HOW)

0 1 2 3 4 5 6 7 8 9 10

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Let's Apply to a Case Study!

Julia – 70 y.o. former competitive soccer player, hiker, tennis player, traveling to Europe in 4 months & wants to be ready for sightseeing

HH: plantar fasciitis , R hip OA

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Decisional Balance Sheet

Julia	Disadvantages	Advantages
No Change	Might need hip replacement Will be in pain in Europe Will need to quit tennis	Can keep living life Pretty good "as is"
Change	Takes time Feet and hips hurt during exercise	Complete the Spanish Steps! Get better at tennis Take longer/tougher hikes Less pain in the feet & hips

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Importance & Confidence Scales

- Measures MOTIVATION and SELF-EFFICACY
  - How Important (WHY) & How Confident (HOW)?
- Generates "Change Talk"
  - Importance: Why is it a A instead of B? (WHY)
  - Confidence: What would it take to go from X to Y? (HOW)

0 1 2 3 4 5 6 7 8 9 10

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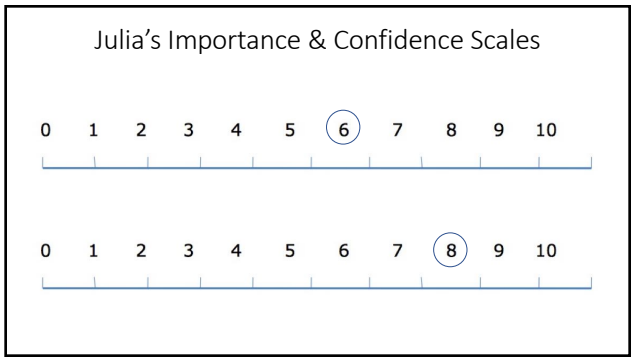
Julia's Importance & Confidence Scales
0 1 2 3 4 5 6 7 8 9 10
0 1 2 3 4 5 6 7 8 9 10

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2021 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or **NO.**	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ **OR** high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:**	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:**	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it **does not limit your current ability** to be physically active. **PLEASE LIST CONDITION(S) HERE:**	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

☑ **If you answered NO to all of the questions above, you are cleared for physical activity. Please sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.**

- Start becoming much more physically active – start slowly and build up gradually.
- Follow Global Physical Activity Guidelines for your age (https://www.who.int/publications/i/item/9789240015128).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and NOT accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

PARTICIPANT DECLARATION

If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

⚠ **Delay becoming more active if:**

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at www.eparmed.com before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

05-11-2020

2021 PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?

If the above condition(s) is/are present, answer questions 1a-1c. If **NO** ☐ go to question 2

1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? YES ☐ NO ☐

1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? YES ☐ NO ☐

2. Do you currently have Cancer of any kind?

If the above condition(s) is/are present, answer questions 2a-2b. If **NO** ☐ go to question 3

2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck? YES ☐ NO ☐

2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm

If the above condition(s) is/are present, answer questions 3a-3d. If **NO** ☐ go to question 4

3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) YES ☐ NO ☐

3c. Do you have chronic heart failure? YES ☐ NO ☐

3d. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? YES ☐ NO ☐

4. Do you currently have High Blood Pressure?

If the above condition(s) is/are present, answer questions 4a-4b. If **NO** ☐ go to question 5

4a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

4b. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) YES ☐ NO ☐

5. Do you have any Metabolic Conditions? This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes

If the above condition(s) is/are present, answer questions 5a-5e. If **NO** ☐ go to question 6

5a. Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies? YES ☐ NO ☐

5b. Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness. YES ☐ NO ☐

5c. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet? YES ☐ NO ☐

5d. Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)? YES ☐ NO ☐

5e. Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future? YES ☐ NO ☐

2021 PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome

If the above condition(s) is/are present, answer questions 6a-6b. If **NO** ☐ go to question 7

6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

6b. Do you have Down Syndrome **AND** back problems affecting nerves or muscles? YES ☐ NO ☐

7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d. If **NO** ☐ go to question 8

7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

7b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? YES ☐ NO ☐

7c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? YES ☐ NO ☐

7d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c. If **NO** ☐ go to question 9

8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

8b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? YES ☐ NO ☐

8c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? YES ☐ NO ☐

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c. If **NO** ☐ go to question 10

9a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) YES ☐ NO ☐

9b. Do you have any impairment in walking or mobility? YES ☐ NO ☐

9c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c. If **NO** ☐ read the Page 4 recommendations

10a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? YES ☐ NO ☐

10b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? YES ☐ NO ☐

10c. Do you currently live with two or more medical conditions? YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

2021 PAR-Q+

If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME ______________________ DATE ______________________

SIGNATURE ______________________ WITNESS ______________________

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER ______________________

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
[illegible]

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

01-11-2020

Decisional Balance Sheet

	Disadvantages	Advantages
No Change		
Change		

HEALTH & ACTIVITY QUESTIONNAIRE

Date: _____

I. PARTICIPANT INFORMATION

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____
number street city state zip

EMAIL: _____

PHONE: Home ( ) _____ Cell ( )_____

BIRTHDATE: __ __/ __ __/ __ __ AGE: _____ GENDER: _____
mo day year

ESTIMATED HEIGHT: _____ ESTIMATED WEIGHT: _____

Have you attempted to change your weight in the past year? Yes No

PRIMARY PHYSICIAN: _____
Name Affiliation Phone

SPECIALIST PHYSICIAN: _____
Name Affiliation Phone

EMERGENCY CONTACT: _____
Name Relationship Phone

II. MEDICAL HISTORY

ESTIMATED DATE OF LAST PHYSICAL EXAM (MONTH/YEAR): _____

Is there a FAMILY HISTORY of fatal heart attack/sudden death?

Father	YES	NO	Age at Death: _____
Mother	YES	NO	Age at Death: _____
Brother(s)	YES	NO	Age at Death: _____
Sister(s)	YES	NO	Age at Death: _____

Are you a type 1 or type 2 diabetic? YES NO Year Diagnosed: _____

Is your diabetes in control? YES NO Do you take insulin? YES NO

Do you experience hypoglycemia (low blood sugar) during or after exercise? YES NO

Do you ever experience light-headedness or blackouts during exercise? YES NO

PLEASE CHECK BELOW IF YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS (specify below):

Angina (chest pain)	_____	**Heart attack**	_____
Irregular heart beat (arrhythmias)	_____	**Ischemia**	_____
High blood pressure	_____	**Narrowing aorta**	_____
High cholesterol	_____	**Uncontrolled heart failure**	_____
Cancer	_____	**Acute pulmonary embolus**	_____
Asthma	_____	**Myocarditis/ pericarditis**	_____
Stroke	_____	**Dissecting aneurysm**	_____
Acute infections	_____	**Electrolyte abnormalities**	_____
Thyroid Malfunction	_____	**Neuromuscular disorders**	_____
Musculoskeletal disorders	_____	**Anemia**	_____
Kidney Problems	_____	**Osteoarthritis**	_____
Rheumatoid Arthritis	_____	**Digestive Diseases**	_____

Specify_____

Specify_____

Specify_____

Specify_____

Specify_____

List any musculoskeletal/joint issues/injuries (e.g., arthritic joints, spinal conditions):

_____

_____

_____

_____

Have you had any accidental falls in the past 12 months? YES NO

If YES, please list each fall, the date it occurred, and the circumstances related to the fall:

_____

_____

_____

PLEASE INDICATE BELOW ANY MEDICATIONS THAT YOU ARE TAKING

Medication/dosage: _____ **Purpose:**_____

Medication/dosage: _____ **Purpose:**_____

Medication/dosage: _____ **Purpose:**_____

Medication/dosage: _____ **Purpose:**_____

Medication/dosage: _____ **Purpose:**_____

Medication/dosage: _____ **Purpose:**_____

III. HEALTH-RELATED BEHAVIORS

Do you smoke or have you smoked in the last 6 months? YES NO

If you do smoke, indicate number of cigarettes smoked per day:
Less than 10 10-20 20-40 Over 40

How many days per week do you accumulate at least 30 minutes of physical activity?

0 1 2 3 4 5 6 7 days per week

How many days per week do you spend at least 20 minutes doing vigorous exercise?

0 1 2 3 4 5 6 7 days per week

Can you walk ~2 miles (30 minutes) briskly without stopping? YES NO

IV. OCCUPATIONAL AND RECREATIONAL ACTIVITIES AND BEHAVIORS

List your current occupations/hobbies & if they involve repetitive movement or prolonged sitting:

Activity: _____ Repetitive movements/prolonged sitting? YES NO

Activity: _____ Repetitive movements/prolonged sitting? YES NO

Activity: _____ Repetitive movements/prolonged sitting? YES NO