
The Missing Prescription: Why Strength Training Belongs in Health Care
Applications from the [*GSA KAER Toolkit on the Management of Obesity in Older Adults*](#)
Momentum Discussions Podcast from the Gerontological Society of America
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	Host: Elana Kieffer Blass, MBA Director, Strategic Alliances, GSA
	Guests: Elizabeth Joy, MD, MPH, DipABLM, FACSM Chairperson, Exercise is Medicine Host, She Leads Science
	Paige Denison, BS, PAPHS Director – Health, Wellness, and Project Enhance Sound Generations

Announcer:

Welcome to the Gerontological Society of America's Momentum Discussions, where we explore groundbreaking topics in the field of aging.

Elana Kieffer Blass:

Welcome to this GSA Momentum Discussions podcast episode titled *The Missing Prescription: Why Strength Training Belongs in Health Care*. We are grateful to Lilly and Haleon for their support of [The GSA KAER Toolkit for the Management of Obesity in Older Adults](#) and for this podcast episode. My name is Elana Kieffer Blass, and I'm the Director of Strategic Alliances at the Gerontological Society of America. I am pleased to serve as the host for today's Momentum Discussion. Today's conversation focuses on Exercise is Medicine (EIM), a global health initiative managed by the American College of Sports Medicine (ACSM), aimed at making physical activity assessment and promotion standard in clinical care, connecting health care with evidence-based physical activity, and providing resources for people everywhere, of all abilities. I am delighted to be joined by two professionals who are leaders in this movement: Dr. Liz Joy, a family sports and lifestyle medicine physician and chair of Exercise is Medicine, leading national efforts to treat exercise as a vital sign in clinical practice, as well as Paige Denison, a key leader in the active aging initiative for Exercise is Medicine. Paige and Liz, welcome, and thank you for joining me today.

Liz Joy:

Thank you so much for having us.

Paige Denison:

Yes, it's really a pleasure to be part of this conversation. Thank you.

Elana Kieffer Blass:

We have lots of questions, and we'll get right into it. We'll start with you, Liz. Can you please take us back to the start of Exercise is Medicine? What was the light bulb moment or the specific gap in the health care landscape that convinced the American College of Sports Medicine, or ACSM, that exercise needed to be formally integrated into clinical care?

Liz Joy:

This is a great question. I would love to answer it. It started in the early 2000s with Dr. Bob Sallis, a friend and colleague of mine at Kaiser Permanente in California. We were at a meeting when an exercise physiologist posed the question, "What is health care doing to address obesity and physical inactivity?" I must admit, I was dumbfounded, sitting there in my chair. We were at a hotel, sitting in a conference room. I remember doodling on a piece of paper with the hotel logo at the top and saying, "What do we need?" We need a physical activity vital sign. Because the vital signs are the first thing that the physician sees when they walk into an exam room. I mean, they see the patient first, but if you're looking at a chart or you're looking at the electronic health record, what you see is the patient's weight, their height, their blood pressure, their heart rate, their temperature, and, of course, those are the things you talk about.

If we have physical activity and vital signs, we should discuss physical activity regularly at every visit. Dr. Sallis and I talked about that at the meeting. He went back to Kaiser Permanente, where he developed the exercise vital sign.

I initially took my work back to the University of Utah and then to Intermountain Health care. We developed the [Physical Activity Vital Sign](#) just a few years later. They were adopted by both of our health care systems, integrated into electronic health records, and that really became the start of Exercise is Medicine. Dr. Sallis was stepping into his role as president of ACSM, and in partnership with the American Medical Association (AMA), we launched Exercise is Medicine in 2007.

Elana Kieffer Blass:

Paige, most people know that exercise is, quote-unquote, good, but what does it mean to treat physical activity as an actual vital sign in a clinical setting? And what does that look like in practice in the clinic?

Paige Denison:

Really, it starts very simply, just asking how often and how long someone's moving each week. But the shift, as Liz indicated, is treating it like any other vital sign and acting on it. Within an age-friendly health system, within GSA, we talk a lot about the geriatric five M's, right: mind, mobility, medication management, multi-complexity, and what matters most. Within that, and especially thinking about mentation and mobility, if someone's not moving enough, it's not just noted; it becomes part of the care plan. It really signals that movement is essential to maintaining function, independence, and overall well-being as we age.

Elana Kieffer Blass:

Liz, for a patient who has never received one, what does a formal exercise prescription look like compared to, let's say, a standard gym recommendation that a physician might say off the cuff?

Liz Joy:

Most people are familiar with what a medication prescription looks like. Maybe it comes on a white piece of paper. It has lots of abbreviations and acronyms that no one understands, and a signature that no one can read. Now, of course, we have electronic prescriptions that are sent automatically to the pharmacy. We don't have electronic prescriptions for fitness facilities. It's probably going to be written down, but I want to take a step back, and I really think a lot has to happen before we even get to an exercise prescription. We use evidence-based behavior change frameworks to help us talk to patients and people about physical activity and exercise. and we've largely adapted and adopted the framework from tobacco cessation, which was the Five As, now we broaden it to Six As, right, and that first A is ask, and that's really using the physical activity vital sign at the point of care, it's collected at every single visit, and it gives us a current picture of what that person is doing about physical activity.

Are they getting zero minutes on zero days? Are they getting 15 minutes on three days, or 30 minutes on five days, and meeting the recommended level of aerobic physical activity? The first A is Ask; that's using the paths. The second A is Advise, right? No matter what someone is doing, we want to advise them to engage in regular movement in a way that is clear, understandable, and personalized, because the clinician, of course, knows their patient. Next is assess, which assesses readiness to change. It's also assessing other comorbid health conditions that that individual might have. Once you've done that, then you move into assist. Assist can be as simple as providing more advice around physical activity and providing a physical activity prescription, maybe a referral to an exercise professional.

I'll come back to the prescription in a minute. The next A is agree. When you're agreeing on a plan, short-, medium-, and potentially even long-term goals, and lastly is arrange or schedule follow-up. In the same way that we're going to arrange follow-up for someone we have prescribed a new medication for, we're going to arrange follow-up to understand better how that individual's doing in participating in more or different physical activity.

For the exercise prescription itself, we typically use the FITT principle. We love acronyms in health care. This one stands for frequency, intensity, time, and type. Ideally, we want people to be active on most, if not all, days of the week. And that can be for as little as 10 or 15 minutes. Ideally, people get about 150 minutes per week of aerobic physical activity, during which their heart rate is elevated and their breathing is harder than normal.

But I really think people need to start where they are, use what they have, and slowly but surely increase activity to the point that makes the most sense for them. Not everybody wants to do the same type of activity. Some people walk; walking is how most American adults meet the aerobic physical activity guidelines. Others may be rolling. They may be walking with a walker. They may be in the pool; they may be doing a group exercise class, depending on the type of activity somebody wants to do. Intensity can be light, moderate, or vigorous. Light intensity would be like a casual walk. Moderate is a brisk walk. Vigorous would be more akin to jogging. That's what the exercise prescription would look like coming from a health care provider.

Elana Kieffer Blass:

I like that, with the Six As, there's the KAER model; they're similar. We discuss that within that framework.

Paige, many people, when they hear the word exercise, they immediately think of cardio. Liz just talked about how walking is a very common way that people get cardio exercise. How does resistance training fit into this medical model of exercise? Why has it historically been underutilized?

Paige Denison:

Yes, I love that Liz just talked about the Six As because, I mean, the Six As are how you get access to the health care system, right? It's what it's all about.

Then we think about the 5Ms we talk about a lot in geriatrics, which is about whether the care's appropriate for older adults once they access the system, right? These two things work nicely together. When we talk about healthy aging, strength training really sits right in the middle of the 5Ms, particularly that mobility piece. It allows people to keep doing the things that are meaningful in their lives. Historically, it has been really underutilized, but we're really seeing a shift right now.

Strength training's not just about fitness; it's about preserving independence. It's about preventing falls. It's about supporting long-term quality of life. Part of the reason that's becoming such a priority is that people are living much longer than ever before. We naturally begin losing muscle as early as our thirties. That decline accelerates with age if we're not actively doing something about it, right? When life expectancy was closer to 65, age-related muscle loss may not have been as significant a concern. But when we see people today live well into their eighties, nineties, and beyond- my parents are 93 and 97 and, in their own home, maintaining strength is just essential for preserving function, independence, and the quality of life as you age.

Liz Joy:

We do have a long way to go in getting older adults engaged in resistance training. The most recent statistics show that only about 14% of adults aged 65 and older engage in any form of strength training two times per week, which is the recommended guideline. And there are many reasons for that, right?

Paige Denison:

One of them is, if you'd agree, "What's strength training?" People think about that, right? Is it barbells in a gym? Do my bands count in my seated aerobics class, or is it picking up the shovel and using the wheelbarrow in my garden? I mean, yes, it's all those things, right and more. We have a lot of education to do, which is why it's great to be here talking about this today.

Liz Joy:

There's what I referred to a couple of weeks ago as either strength or resistance training literacy,

There is still confusion around terms like resistance training and strength training. Are they the same? What counts? Do bodyweight exercises and resistance bands count? Do you have to go to a gym, wear workout clothes, or work with a trainer? We also use terms like major muscle groups, reps, and sets without always explaining what they mean. These assumptions, especially around strength training, can make it harder for people to get started because they may feel afraid, unsure, or uninformed. That is one reason we launched Exercise is Medicine Active Aging in partnership with organizations such as GSA. We are educating not only the broader public, but also health care providers, so they feel more comfortable and confident talking with patients, especially about resistance training.

Elana Kieffer Blass:

Somewhat anecdotally, strength training has become easier to attain, especially since the pandemic, when people had to do more exercise at home, and with Amazon you can order resistance bands and dumbbells very easily. My dad has an avid weight-lifting routine, since COVID, when he couldn't go to the gym anymore, he just started lifting weights with water bottles, water gallons, and textbooks. And I think that with technology and virtual exercise classes, it has become easier in many ways, and you don't have to go to the gym to do that.

Liz Joy:

Agree. The quality of digital and virtual exercise has improved rapidly. Certainly, we were moving in that direction pre-pandemic, but it's really accelerated since then. I've been really impressed with some of the programs that I've become familiar with and wouldn't hesitate to refer a patient to them.

Elana Kieffer Blass:

Including one-on-one, so you can really be tailored as if you're in the gym. Switching gears, Liz, it's very well known that physicians are often short on time during their clinical visits. How does this EIM initiative help a busy doctor integrate activity assessment into an already very short appointment, typically 15 minutes?

Liz Joy:

Happy to share some information here. One is that the exercises on the [Exercise is Medicine](#) website are full of information that would help any health care system, physician leader, or practicing clinician access information on how to be more comfortable and more effective when talking to their patients about regular physical activity and exercise.

We have something called the [Health Care Providers Action Guide](#). This wonderful guideline walks people from the very beginning all the way through team-based care focused on helping them achieve and sustain physical activity. Within that, we have used an SBIRT framework, again, another acronym, S-B-I-R-T, that we adopted in this case from substance use disorder. It stands for screening, brief intervention, and referral to treatment. We don't really treat people with physical inactivity, but I'll come back to that.

But the screening is done through [the Physical Activity Vital Sign](#). The brief intervention is really, Mrs. Jones, it would be helpful for your arthritis if we got you out of your chair and helped you to move more. Or it could be to somebody who is fully engaged in physical activity to give them an "attaboy" or an "attagirl" and say, "Way to go. We're very good at pointing out when people aren't doing something; we're less inclined to acknowledge when they are. I always think that the "attaboys" and the "attagirls", they, they fall into brief intervention. But that's also where we use the Five As to assess readiness for change and gain a broader understanding of comorbid health conditions and pharmacotherapy that may influence their ability to engage in regular physical activity.

Then there's the referral-to-treatment, which, again, isn't much of a treatment but is about connecting people to resources. Sometimes, based on their resources and their choice. It may be that someone with significant knee osteoarthritis needs to see a physical therapist before seeing an exercise professional. Or somebody who really wants to talk about physical activity in the context of weight management sees a registered dietitian who also talks about physical activity in the context of energy balance. Or they may be ready to move into a medical fitness situation, where they feel a little safer and are observed by someone with more expertise, or to community fitness or self-directed physical activity. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a framework that primary care physicians know, since they're caring for such a large percentage of the population.

We thought it would be easy for people to run through, keep it in mind, and do so rather quickly during a visit. On the [Exercise is Medicine](#) website, there's information on time-based counseling and billing, as clinicians need to be compensated for their time. This takes time, and it takes time over time. Behavior change doesn't happen during a visit, and people do not get well and stay well in the doctor's office; that happens in their free-living life. We revisit those conversations about physical activity repeatedly, and that takes time, but we talk about how they can do that. Then lastly, I would say that all of this does not rest on the shoulders of the physician, right?

I mean, the physician or nurse practitioner or physician assistant, whoever it is that's providing care, they have a whole team around them. I work very closely with my clinical support staff, so they could take on some of those responsibilities while I move on to see my next patient. It's about how to utilize the knowledge, the skills, and the expertise of the entire team. Everyone works at the top of their license to deliver the right care to the right patient for the right reasons, at the right time.

Elana Kieffer Blass:

At GSA, we pride ourselves on having a multidisciplinary membership and on the importance of a multidisciplinary approach to geriatric care. That makes a lot of sense, and for practical reasons as well. Picking up on one thing that Liz said, Paige, one of the hardest parts that she referenced is what happens next once someone gets this prescription? How does EIM help connect patients with qualified exercise professionals, programs, and places who can safely guide them through strength training and other types of exercise?

Paige Denison:

Liz has stated it very well. That this is the big opportunity, right? What happens after the visit? This is what we're working on with the new EIM [Active Aging Initiative](#), creating resources around these areas because over at ACSM, just like GSA, has a multidisciplinary cross-sector membership, really looking at how the researchers, how the educators, how the partnerships all can lift and grow this work and deepen the resources to do this. Because we can't just identify a need. We have to connect people with the right support if they're going to take that action as Liz talked about.

Our vision for exercise, medicine, active aging, which is a new initiative, is to really create bridges to the community programs, to the exercise pros, to the places who really understand older adults and understand chronic conditions, so that they get the right support. That way, turning that physician's recommendation into a pathway, right? And ideally, a bidirectional pathway for follow-through.

Elana Kieffer Blass:

You mentioned chronic disease. Liz, why is it important to seek out EIM-credentialed professionals, especially for patients with chronic disease or at high risk for other challenges? And how can you tell when a program is a good fit?

Liz Joy:

The EIM credential provides exercise professionals with additional training specifically for working with clients who have chronic diseases, whether that's heart disease, cancer, arthritis, or cognitive issues. It also teaches them how to interact with the health care system. I mean, we're siloed, right? In our different worlds, health care, hospitals and clinics do health care, and gyms do fitness, right? But we know that if we want to stem the tide of chronic disease and diminish its impact on health span and costs, we need to better connect health care with health and fitness, and it needs to be bidirectional. Thus, we want physicians and clinicians to understand how to connect people with exercise professionals. Similarly, we want the exercise professionals to know how to communicate effectively with the health care provider, right?

Because that helps to build trust; if the health care provider does not trust the person, they are unlikely to refer to them. The EIM credential is one way we build trust: we build expertise for the exercise professional and trust with the patient. A major reason people, particularly older adults who have developed some chronic conditions, don't exercise is that they are afraid. They are afraid of pain, which is one of the biggest reasons why they do not engage in regular physical activity, or fear of an adverse consequence.

Dr. Barry Franklin, at Henry Ford Health System, past president of the American College of Sports Medicine, he's done a lot of work in this area, particularly with cardiovascular disease, showing that, again, people are very fearful after having a heart attack or maybe being told they have heart failure that, oh, if my heart is failing, I do not want it to beat too fast. Of course, it turns out that the best thing they can do for your heart is to keep the muscles strong. EIM-credentialed professionals build trust with the clinician. They have the knowledge and skills to work with patients with chronic disease and can help overcome some of the common barriers they face.

Elana Kieffer Blass:

And we've touched on this, but what does a great handoff look like between the health care provider and the EIM credential professional?

Liz Joy:

Good question. I'm going to talk about it in two different ways. One is inside the health care system, and the other outside it. In health care, physicians are comfortable connecting patients with physical therapists. They are licensed health care providers within the system. Oftentimes it may be appropriate for someone to see a physical therapist first, particularly if they have musculoskeletal or neuromuscular conditions. Maybe they have experienced a recent heart attack, or they have heart failure, and we can connect them to cardiopulmonary rehab. Again, a trusted resource within the health care system. And as I mentioned, to a registered dietitian, if they want to do more physical activity in the context of weight management or nutritional management of another condition. For example, somebody who is on a GLP-1 receptor agonist, who also is going to really work on lifestyle behaviors in an effort to try and achieve clinically meaningful weight loss.

That's easy because it's within the health care system; physicians are very familiar with it and can talk about the services those professionals provide. That makes for a warm handoff. Outside health care, it's a little bit harder. I know that, for me personally, I have developed relationships with exercise professionals, particularly at local gyms near the clinic where I work, who focus on training older adults. I also would, depending on the patient's insurance, some of the Medicare Advantage plans have a built-in fitness benefit. I knew the participating gyms in the local area; I could refer to a particular gym that may be, again, relatively close to where they live or work.

I recommend that people participate in some state health department-based programs. Walk With Ease is offered free of charge through local health departments in and around Salt Lake City, Utah, where I live. I led the Walk with the Doc program for Intermountain Health. In some of our communities, we combined Walk with Ease with Walk with a Doc. We could refer directly to that, and oftentimes those sessions were led by clinicians in the clinic, so the patients were familiar with them. The last thing I will mention, which is maybe a little less of a warm handoff but can still be a good one, is to connect people through a tool called US Reps, or the US Registry for Exercise Professionals.

It's a registry where I can do it right at the point of care, and I can enter in all sorts of information about the location and the professional I'm looking for. It'll pull up potentially hundreds of certified exercise professionals within a defined geography. Sometimes I would recognize a name; sometimes the patient would; sometimes I just showed them how to do it. They could do it in the comfort of their own home and find somebody maybe at a gym where they already had membership. But either way, it was me taking the time to say, this is why this is the right option for you. This is the reason why you might consider this. It's all about personalizing the message.

Elana Kieffer Blass:

Paige, can you walk us through how the [RX for Health Series](#) tailors exercise and movement for someone dealing with a specific condition, such as type 2 diabetes or hypertension?

Paige Denison:

This is another great American College of Sports Medicine (ACSM) resource, an exercise and medicine resource that supports the clinician in making exercise part of the care plan. The RX for Health, as it's called, is on the ACSM website; those resources are helpful because they actually translate the research into this clear guidance in a one-pager on just a wide variety of topics that can be handed to the patient and reinforce the conversation that Liz was talking about, right? For example, combining aerobics and strength training for diabetes, or how to tailor intensity for hypertension. Because we're talking a lot about older adults specifically today, it really reinforces function. Thinking a lot about helping people stay strong and steady and thinking about cognitive engagement as well as covering in these resources—boy, Liz, it just covers the gamut of conditions with older adults. Clinical experts and researchers write them. Really valuable, trusted information that can just be printed and shared, right? It really is a terrific resource. I can't recommend them highly enough.

Liz Joy:

There are about 35 of them now live on our website. All of them are available in both English and Spanish.

Elana Kieffer Blass:

Liz touched on some of this, but Paige, how do you think we can better connect the health care system with community fitness resources so patients don't feel lost once they leave the clinic?

Paige Denison:

It's a great question. Liz did a really great job, and I'm going to add a little more from the community perspective. "Go exercise" doesn't work. That's how we got here. But it's this clear next step with, with guidance somewhere to go and what to expect, right? Do some expectation setting with the patient. We know through research, right, that if a physician guides a patient to do exercise, they're much more likely to do it and act on that information. This reduces friction and builds confidence. Ideally, there's communication back. It feels like a continuum of care rather than some disconnected experience. Liz mentioned US Reps, which is a great resource. Certainly, if you're lucky enough to have Liz as your physician, you've got this understanding of what's available in the community.

We need to leverage trusted community resources. Liz mentioned the county health department in aging, but these resources that already are helping older adults navigate services, right? Your Area Agencies on Aging, your senior centers, your other community hubs these organizations are often the front door to local programming, from Meals on Wheels to caregiver support, and they can help connect people with the appropriate fitness and wellness and healthy aging resources too. The future is being created right now. A lot of us know, maybe in our own states or in the catchment areas of our health care organizations, a little bit about what's going on, but we're starting to see stronger bidirectional referral systems connected to the EHR.

It's not all the way there yet, but many systems have them in place so health care providers can not only make a referral but also receive confirmation that the referral was acted on. Which is, I mean, that's where we're trying to go. That's certainly the work that we're endeavoring to support through EIM Active Aging. That closed-loop communication really strengthens the accountability piece, which is important, and improves coordination. It helps ensure that people don't fall through the cracks once they leave the clinician's office.

Elana Kieffer Blass:

Absolutely. For both of you, what have I not yet asked about that is important for our listeners to know, if anything?

Liz Joy:

Oh, I have one thing I feel compelled to share with the audience: the most dangerous place for almost any person is not the gym. It's the couch: whether that person has heart disease, diabetes, cancer, or arthritis, regular physical activity and improved fitness are almost universally associated with better health outcomes. Yes, people need to embody that thought. The most dangerous place I can be is the couch. I'll leave you with that.

Paige Denison:

I love that and echo it. And I also want to say, I mean, there are a lot of people out there who just had a bad experience, right? They don't like to exercise. You can take a step back and think, this isn't really about exercise. It's about helping people be able, right? That they're able to think clearly, and do what matters to them, and have a good quality of life. When we treat strength and movement as essential parts of care, we can shift the entire trajectory of aging. That's, I mean, that's exciting, right? That's the opportunity that's in front of us. That's what I would say.

Elana Kieffer Blass:

Absolutely. Paige and Liz, thank you both for sharing your expertise, guidance, and vision for transforming how we think about health. You've shown us that exercise is not just a lifestyle device, but medicine itself. Please check out their website at exerciseismedicine.org. To our listeners, thank you very much for joining us for this episode of the GSA Momentum Discussion podcast. Once again, thank you, Paige and Liz, for joining us today.

Announcer:

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