Impact of a Blood Pressure Practice Initiative on Attitude, Practice Behavior, and Knowledge among Outpatient Rehabilitation Providers: An Observational Study

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Impact of a Blood Pressure Practice Initiative on Attitude, Practice Behavior, and Knowledge Among Outpatient Rehabilitation Providers: An Observational Study

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Human Subject Institutional Review Board Approval: Oakland University # 657553 and Henry Ford Health System #9146.

Purpose: The purpose of this study is to describe the impact of a blood pressure (BP) educational initiative on the attitude, practice behaviors, and knowledge of outpatient (OP) physical therapists. Methods: An observational pre-test and post-test study design was initiated using a sample of convenience at 12 OP rehabilitation clinics. A 4-phase protocol included (1) evaluation of BP equipment, (2) pre-test questionnaire, (3) attendance at a 1-hour lecture on BP practice recommendations, and (4) performing BP measures on patient evaluations for 1 week followed by the post-test questionnaire. Descriptive statistics reported demographics, whereas a paired t test compared means of the presurvey and postsurvey responses with statistical significance set at $P < .05$. Results: Of the 55 therapists included, 70.9% were female and 29.1% male, whereas 41.8% and 58.2% reported having ≤15 and >15 years of experience, respectively. A significant improvement in BP attitudes ($P = .02$), practice behaviors ($P = .001$), and knowledge ($P = .002$) was identified. Conclusions: An educational initiative that provided BP assessment tools, a 1-hour evidence-based BP lecture, a decision-making reference, and a directive to perform valid and reliable BP techniques and interventions resulted in positive changes to an OP therapists attitude, immediate practice behavior, and knowledge of BP. (Cardiopulm Phys Ther J. 2020;31:47–56) Key Words: blood pressure, physical therapy, education

INTRODUCTION

Blood pressure (BP) assessment of patients and clients under the care of physical therapists (PTs) is instrumental to identify baseline cardiovascular risk, design an exercise prescription, and monitor responses to exercise. Furthermore, BP assessment is well established as an important aspect of care irrespective of a patient’s pre-existing cardiovascular diagnosis.2,3 Despite evidence supporting the need for routine BP assessment, previous studies report PTs practicing in an outpatient (OP) setting are measuring BP at low frequency.4,5 Although it is conceivable, clinicians may perceive the use of clinical judgment and previous experience as plausible rationale to determine the need to measure a BP; a study by Feldman et al.6 concluded clinicians made poor clinical decisions using these techniques in isolation. The study further established PTs were unable to predict a patient’s hypertensive (HTN) status.
using a review of the individual’s medical history or a visual inspection. Furthermore, Vanzant et al. have reported OP PTs to report significantly lower clinical practice behavior agreement when educating individuals on cardiovascular disease (CVD) risk factors, developing of CVD prevention programs, and monitoring patient with known CVD when compared with other areas of PT practice. This is of specific concern given evidence suggesting prevalence rates of elevated BP measures among individuals under the care of PTs, even in the OP practice setting, are in congruence and possibly in excess of rates reported in the general population.

Although evidence for causation for BP omission specific to OP PTs is incomplete, time and inadequate equipment have been cited as a potential barrier to measuring BP. Gaps in knowledge regarding the criterion for classifying a BP as suboptimal have also been reported. This is additionally confounded by recent changes from the recommended BP classifications and criterion of normotensive, pre-HTN (P-HTN), or HTN (Table 1) to the more recently recommended normal, elevated, stage I hypertension, and stage 2 hypertension classifications published in late 2017 (Table 2). Variation among clinicians in regard to knowledge and standardized practice behaviors is not unique to PTs as reports from other health care professions suggest deficiency. It further suggests the constructs of the Theory of Planned Behavior support the prediction of a specific behavioral outcome when a behavior is intended, in this case accurately measuring a BP.

Arena et al. suggest that current attitudes, practice behaviors, and knowledge among OP PTs specific to BP examination and intervention are not in line with recommended practice. This is of critical concern given that direct consumer access to PT services is now available in all 50 states, whereby PTs may be the point of entry for an individual into the health care system. Educational strategies to enhance positive attitudes toward BP measurement, to augment evidence-based practice habits, and to bridge knowledge gaps are necessary to optimize the health and wellness of individuals under the care of OP PTs. Therefore, the purpose of this study is to describe the impact of a BP educational initiative on the attitude, practice behavior, and knowledge of OP PTs and occupational therapists (OTs).

METHODS

Research Design

After obtaining Henry Ford Health System and Oakland University Institutional Review Board approval to assure the rights of the participants were protected, a observational research design using a pre-test and post-test was initiated.

Sampling Criteria

A sample of convenience from 12 OP clinics of one hospital-based health system was utilized. The clinics are not exclusive in regards to the nature of patient impairments and populations served. However, musculoskeletal conditions and adult residents of urban and suburban regions of Metropolitan Detroit in Southeast Michigan are most frequently encountered. Although all employees were invited to participate in the education experience, only PTs and OTs were offered an option for study inclusion because these disciplines were responsible for initial evaluations and care coordination of patients. One hundred and nine PTs and OTs were employed at the 12 clinics. However, given potential for varied work schedules, contingent and part time employment, medical leave and vacation schedules, and an employee’s choice to not participate in the study, a robust retention and 20% attraction could provide 87 therapists for testing.

Phase 1. The investigator conducted an evaluation of available BP measurement equipment at each clinic in September of 2014 as a component of phase 1. The numbers, sizes, and functionality of available BP equipment was assessed. Sphygmomanometers and stethoscopes were each inspected for observable tears, cracks, or wear to the cuff, bulb, and tubing. In addition, gauge calibration was examined using a calibration protocol set forth by the European Society of Hypertension. Clinic supervisors were provided with recommendations for BP equipment purchasing and agreed to obtain before initiating phase 3 of the study. Equipment

TABLE 1

<table>
<thead>
<tr>
<th>Blood Pressure Classifications</th>
<th>Systolic Blood Pressure (mm Hg)</th>
<th>Diastolic Blood Pressure (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>119 or lower</td>
<td>79 or lower</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120 to 139</td>
<td>80 to 89</td>
</tr>
<tr>
<td>Hypertension</td>
<td>140 or higher</td>
<td>90 or higher</td>
</tr>
</tbody>
</table>

TABLE 2

<table>
<thead>
<tr>
<th>Blood Pressure Classification</th>
<th>Blood Pressure Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Less than 120 mm Hg AND less than 80 mm Hg</td>
</tr>
<tr>
<td>Elevated</td>
<td>Systolic between 120 and 129 mm Hg AND diastolic less than 80 mm Hg</td>
</tr>
<tr>
<td>Stage 1: hypertension</td>
<td>Systolic between 130 and 139 mm Hg OR diastolic between 80 and 89 mm Hg</td>
</tr>
<tr>
<td>Stage 2: hypertension</td>
<td>Systolic greater than or equal to 140 mm Hg OR diastolic greater than or equal to 90 mm Hg</td>
</tr>
</tbody>
</table>


recommendations were as follows; one stethoscope for each PT and OT, one standard aneroid BP cuff for every 2 therapists, and one small and one large BP cuff per clinic. In addition, if the clinic provided care to individuals under the age of 12 years, a child size cuff was recommended for purchase. Furthermore, it was recommended annual BP equipment checks be conducted moving forward by the health systems bioengineering department. Contact information for this department was provided to clinic supervisors.

**Phase 2.** Phase 2 was initiated in October of 2014. During this phase, the investigator met with employees at each clinic to explain the study, secure participant consent, and administer the pre-test questionnaire to consenting therapists. Questionnaires and all data collected from each therapist were blinded to the investigator using a therapist created unique identifier. The questionnaire, previously tested for validity and reliability and with precedence for use in a previous study,11,19 was used with the addition of one question aimed at obtaining the discipline to which the respondent identified (PT or OT). Five attitude-focused questions used a Likert-type scale, and 9 practice behavior questions used ordinal responses that were converted to nominal responses to garner replies that were more positive or negative as self-reported by the responder. The questionnaire also included 6 knowledge questions; however, as only the questions requesting therapists indicate BP values defined as P-HTN or HTN would ensure responses with definitive criterion established in the literature, only these 2 queries were used for statistical analysis of change. Responses to the additional knowledge question are descriptively reported. Blood pressure classification was defined using the **Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7)**12 because these were the standard definitions available to therapists throughout the study data collection period. Although the investigators recognize new BP definitions have since emerged into mainstream health care (Table 2), the **JNC7** criterion outlined in Table 1 was used to define normal BP, P-HTN, and HTN for the purpose of this study.

The questionnaire further captured therapist’s demographics including sex, highest PT degree obtained, and years of experience working as a PT. Years of experiences were categorized as either having less than or equal to 15 or greater than 15. In choosing the 15 years of experience cut-off, the authors recognized the physical therapy profession underwent a transition to doctoral prepared entry level clinicians in the past 15-year period. Therefore, both experiential and academic background differences might contribute to difference in the groups. In addition, the JNC7 criteria were introduced approximately 15 years ago and therefore were considered when choosing the 15-year timeframe.

**Phase 3.** On October 28, 2014, and November 11, 2014, phase 3 was conducted. Therapists attended a 1-hour presentation either in person or remotely during a designated departmental in-service timeframe. The same presentation was offered on 2 different occasions to best accommodate work schedules and patient care obligations. Written handouts and an online version of the presentation were available to the learners for reference during and after the presentation. Learning objectives were as follows:

Upon Completion of this presentation, learners will be able to

1. Classify values for normal, pre-HTN, and HTN BP measures.
2. State the potential prevalence of suboptimal BPs in their practice setting.
3. Apply recommendations of the Eighth Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC8)20 BP management algorithm to the delivery of rehabilitation services.
4. Choose correct tools, methodologies, and clinical techniques to obtain a valid and reliable BP reading including (1) use of pulse obliteration pressure to determine maximal cuff inflation level, (2) optimal body position for BP measurement attainment, and (3) best BP equipment choices.
5. Use evidenced-based strategies to progress patients/clients toward optimal BP measurements by (1) educating patients/clients on lifestyle modifications, (2) initiating communication and/or referrals to other health care providers when a suboptimal BP is identified, and (3) identifying BP measures requiring prompt medical attention.

In addition, a rehabilitation provider BP decision-making algorithm was provided to each therapist (Appendix 1) for reference. The algorithm was created by the...
The mean of responses to the preintervention and postintervention questions of attitude are reported in Table 3 with detail for all respondents, males, females, and respondents with greater than and less than or equal to 15 years of experience. A significant improvement in attitude was identified for all respondent ($P = .02$) and also among respondents with less than or equal to 15 years of experience ($P = .01$).

#### Change in Blood Pressure Practice Behaviors

The mean of the responses to the preintervention and postintervention questions of BP practice behaviors is reported in Table 4 with detail for all respondents, males, females, and respondents with greater than and less than or equal to 15 years of experience. A significant improvement in practice behavior was identified for all respondents ($P = .001$) and across all categories (males [$P = .003$], females [$P = .001$], respondents with greater than 15 years of experience [$P = .001$], and less than or equal to 15 years of experience [$P = .011$]). In addition, significant improvements among all subgroups were identified to choose the correct BP cuff size for each patient and most subgroups demonstrated positive change toward standardizing the patient position for BP measurement and in obtaining the BP measure at evaluations.

Respondent self-reported barriers to performing BP measure in the pre-test responses as lack of equipment (n = 13), lack of knowledge (n = 3), and dependent on the...
patients' presentation (n = 1) were eliminated as perceived barriers on the post-test questionnaire. However, the reported barrier of time increased from the pre-test questionnaire (n = 18) to the post-test questionnaire (n = 22).

**Change in Blood Pressure Knowledge**

The mean of the correct and partially correct responses to the preintervention and postintervention questions of BP knowledge are reported in Table 5 with detail for all respondents, males, females, and respondents with greater than and less than or equal to 15 years of experience. In addition, the combined change for questions of knowledge is reported. Overall, knowledge improvements (P = .002) were observed and males and those with greater than 15 years of experience all demonstrated positive improvement that met the significance threshold (P = .01 and P = .01, respectively).

**Blood Pressure Measures and Associated Actions**

Blood pressure measures and associated actions for 259 new patient evaluations were recorded during phase 4. Of these, 26.3% had a measure meeting the normal BP classification, 47.5% the P-HTN, and 26.3% HTN. It is notable that a pre-existing HTN diagnosis was not available to the investigators for analysis. Actions taken by the therapists were as follows: 46.7% (n = 121) took no action, 80.4% (n = 208) informed the patient of their BP reading, 17.8% (n = 46) engaged in a discussion of medication compliance, 14.3% (n = 37) provided education on lifestyle modification that may optimize BP measurement, 1.2% (n = 3) called the physician, modified treatment, or held treatment. There were no patients referred to the emergency department.

Table 6 summarizes the resulting therapists' actions taken when patients' BP readings met the criteria of a normal, P-HTN, or HTN reading. In addition, Table 6 reports difference between BP classifications to each action. Significantly more actions were taken by therapists when a patient was identified as having higher BP readings.

**DISCUSSION**

The purpose of this study is to describe the impact of a BP educational initiative on the attitude, practice behavior, and knowledge of OP PTs and OTs. It is notable, OT data is omitted from this study reporting due to low response frequencies. Routine cardiovascular assessment by OP

<table>
<thead>
<tr>
<th>Attitude Questions</th>
<th>All Respondents</th>
<th>Male</th>
<th>Female</th>
<th>&gt;15 yr of Experience</th>
<th>≤15 yr of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>I feel it is important to take a blood pressure reading on every patient/client during an evaluation or re-evaluation.</td>
<td>2.96</td>
<td>3.11</td>
<td>3.00</td>
<td>3.38</td>
<td>2.95</td>
</tr>
<tr>
<td>I feel it is important to take a blood pressure reading on every patient/client PRIOR to physical therapy treatment.</td>
<td>2.80</td>
<td>2.85</td>
<td>2.69</td>
<td>3.00</td>
<td>2.85</td>
</tr>
<tr>
<td>I feel it is important to take a blood pressure reading on every patient/client AFTER physical therapy treatment.</td>
<td>2.67</td>
<td>2.62</td>
<td>2.63</td>
<td>2.81</td>
<td>2.69</td>
</tr>
<tr>
<td>I feel I am able to take an accurate blood pressure reading.</td>
<td>3.91</td>
<td>4.24</td>
<td>4.13</td>
<td>4.19</td>
<td>3.82</td>
</tr>
<tr>
<td>I feel confident in my ability to educate patients/clients about blood pressure-related findings.</td>
<td>3.22</td>
<td>3.84</td>
<td>3.56</td>
<td>3.81</td>
<td>3.08</td>
</tr>
<tr>
<td>All questions of attitude change</td>
<td>15.6</td>
<td>16.7</td>
<td>16.0</td>
<td>17.2</td>
<td>15.4</td>
</tr>
</tbody>
</table>

A higher mean number indicates a more positive response.

*Met significance level of P < .05.

BP, blood pressure.

Cardiopulmonary Physical Therapy Journal

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PTs is necessary for intervention safety, exercise prescription, and to identify patients in need of a physician referral. Previous reports indicate OP PTs perform BP measures at low frequencies, have knowledge gaps regarding best BP practices, and report time constraints and equipment barriers. Although the current practice culture among OP rehabilitation providers may benefit from educational initiatives addressing misinformed BP practice models, there is paucity of evidence for an instructional design framework with this aim. This study provides a model for one such multimodal educational initiative that demonstrated significant improvements to the attitudes, practice behaviors, and knowledge of OP rehabilitation providers.

When comparing the demographics of the therapists participating in this study to those previously reported by Arena et al. which used the same questionnaire, the investigators note this population had a higher percentage of females (71.2% compared with 58.5%) and therapists with greater than 15 years of experience (57.6% compared with 41.2%). However, this study identified those having greater than 15 years of clinical experience to report significantly more positive changes in BP knowledge, whereas those with less than or equal to 15 years of experience demonstrated significantly improved attitudes toward the BP measures after the study intervention. Although specific causation for these findings requires further examination, it is plausible that the release of the JNC7 criteria, introduced approximately 15 years before

### TABLE 4
Mean of the Responses to the Preintervention and Postintervention Questions of BP Practice Behavior

<table>
<thead>
<tr>
<th>Practice Behavior Questions</th>
<th>All Respondents</th>
<th>Male</th>
<th>Female</th>
<th>&gt;15 yr of Experience</th>
<th>≤15 yr of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>A physical therapy assistant, technician, or other health care provider obtains the blood pressure measurement in my practice setting.</td>
<td>1.76</td>
<td>1.80</td>
<td>1.63</td>
<td>2.00&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.82</td>
</tr>
<tr>
<td>I measure blood pressure during patient/client evaluation or re-evaluation.</td>
<td>1.95</td>
<td>2.35&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.00</td>
<td>2.38</td>
<td>1.92</td>
</tr>
<tr>
<td>I measure blood pressure on a patient/client PRIOR to physical therapy treatment.</td>
<td>1.96</td>
<td>2.13&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.00</td>
<td>1.94</td>
<td>1.95</td>
</tr>
<tr>
<td>I measure blood pressure on a patient/client AFTER physical therapy treatment.</td>
<td>1.93</td>
<td>1.96</td>
<td>2.00</td>
<td>1.94</td>
<td>1.90</td>
</tr>
<tr>
<td>I inform a patient/client of their blood pressure reading after each measurement.</td>
<td>4.38</td>
<td>4.78&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4.19</td>
<td>4.63</td>
<td>4.46</td>
</tr>
<tr>
<td>I standardize the patient/client position each time I perform a blood pressure measurement.</td>
<td>3.93</td>
<td>4.65&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.88</td>
<td>4.63&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3.95</td>
</tr>
<tr>
<td>My clinical site performs yearly retraining of blood pressure measurement techniques.</td>
<td>0.00</td>
<td>0.04</td>
<td>0.00</td>
<td>0.06</td>
<td>0.00</td>
</tr>
<tr>
<td>I use a different size blood pressure cuff depending on the measurement site used for each patient/client.</td>
<td>0.49</td>
<td>0.81&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.63</td>
<td>0.88&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.44</td>
</tr>
<tr>
<td>I measure the maximal cuff inflation level prior to taking a blood pressure measurement.</td>
<td>0.07</td>
<td>0.26</td>
<td>0.00</td>
<td>0.38&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.10</td>
</tr>
<tr>
<td>All questions of practice behavior change.</td>
<td>16.4</td>
<td>18.7&lt;sup&gt;a&lt;/sup&gt;</td>
<td>16.3</td>
<td>18.8&lt;sup&gt;a&lt;/sup&gt;</td>
<td>16.5</td>
</tr>
</tbody>
</table>

A higher mean number indicates a more positive response.

*Met significance level of *P* < .05.

BP, blood pressure.
the study, in combination with a statewide transition to doctoral academic preparation for entry level PTs during that same period may be contributors to knowledge gaps. In addition, suggested changes to the recommended BP classification criteria that were enacted after this study concluded provides an additional conundrum in the effort to provide education in line with the current evidence. Specifically, evidence of baseline knowledge gaps in an OP therapist knowledge of the criteria and definition of P-HTN and HTN are evident despite the JNC7 being published nearly 15 years ago. Changes to these criteria present challenges toward imparting the contemporary knowledge required to make informed clinical decisions. The authors suggest the use of an algorithm, such as the rehabilitation provider BP decision-making algorithm proposed in this study, may be of future benefit because it is not inclusive of specific BP classifications rather a range of BP measures and associated clinically recommended actions.

The authors recognize this study design, inclusive of self-reported behavior change reporting within a few weeks after the required 1 week of BP measures, may not fully encompass sustained behavior change on the part of the therapist. However, as the study’s findings suggest that when a workplace participated in an initiative that expected BP measures be performed, therapists report statistically significant improvements with the behavior change. Therefore, a directive to perform BP measures as a component of routine care from an authority figure may be an integral part of the behavior change process. This occurrence can be observed among PTs practicing in the home health care setting where BP measurement is an expected component of each encounter for Medicare reimbursement and has been reported to occur at a higher frequency than other areas of physical therapy practice. Although future studies are warranted to examine the long-term impact of this type of education model on behavior, enacting workplace policies toward routine BP measure may have an impact on the currently low frequency at which PTs are performing BP measures in the OP practice settings.

The cost burden of HTN extends beyond individuals with this as the primary diagnosis. Hospitalization for HTN as a secondary diagnosis has been reported in excess of $20,000 with 13% of the cost directly associated with HTN BP. Wang et al. suggest a need for fiscally responsible programs that can prevent, manage, and control HTN. This study provides one such cost-effective model that can be incorporated into the daily practice of rehabilitation providers including PTs. Direct clinic costs for this type of program include obtaining adequate BP measurement equipment ($35–$47 for each standard aneroid cuff and stethoscope kit, ie, Moore Brand Blood Pressure Kit with Sprague Stethoscope-Moore Medical, LLC Farmington, CT and Pro’s Combo II DH-American Diagnostic Corporation, Hauppauge, NY, respectively) as well as costs associated with clinicians time and associated patient care revenue lost while attending the 1-hour training. Performing a manual BP during an evaluation or intervention requires skill to (1) acquire the valid BP measurement, (2) formulate an evidence-based action plan, and then (3) act on the associated clinical decisions. Therefore, this sequence meets the definition of skilled and medically necessary, so is an essential element to include in each patient’s medical record.

**Study Limitations**

The investigators acknowledge this study only reports the immediate impact of the educational initiative and not the longitudinal changes to attitudes, behaviors, or knowledge. In addition, utilization of therapists from only

### TABLE 5

Mean of Correct and Partially Correct Responses to the Preintervention and Postintervention Questions of BP Knowledge

<table>
<thead>
<tr>
<th>Knowledge Questions</th>
<th>All Respondents</th>
<th>Male</th>
<th>Female</th>
<th>&gt;15 yr of Experience</th>
<th>≤15 yr of Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
</tr>
<tr>
<td>Blood pressure value(s) considered to indicate prehypertension:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>0.73</td>
<td>0.88ᵃ</td>
<td>0.80</td>
<td>0.93</td>
<td>0.70</td>
</tr>
<tr>
<td>Diastolic</td>
<td>0.57</td>
<td>0.82ᵃ</td>
<td>0.50</td>
<td>1.00</td>
<td>0.61</td>
</tr>
<tr>
<td>Blood pressure value(s) considered to indicate hypertension:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic</td>
<td>0.77</td>
<td>0.86</td>
<td>0.73</td>
<td>0.93</td>
<td>0.78</td>
</tr>
<tr>
<td>Diastolic</td>
<td>0.60</td>
<td>0.84ᵃ</td>
<td>0.56</td>
<td>0.93</td>
<td>0.61</td>
</tr>
<tr>
<td>All questions of knowledge change</td>
<td>2.77</td>
<td>3.44ᵃ</td>
<td>1.67</td>
<td>3.80ᵃ</td>
<td>2.83</td>
</tr>
</tbody>
</table>

A higher mean number indicates more correct and partially correct responses. ³Met significance level of P < .05. BP, blood pressure.
one health system may have introduced bias and reduced generalizability of the study findings. Control for the number of BP measures a therapist obtained during phase 4 was not addressed, but would have been of benefit in determining if an optimal frequency exists to bring about change in a therapist’s attitude, practice behavior, or knowledge. Finally, at the conclusion of this study, recommended change to the BP classification system were introduced, therefore modifications to the questionnaire used in this study before use in future investigations is warranted.

**Future Research**

Future research inclusive of long-term impact studies of this educational initiative, outcomes of varied educational and policy-related initiatives, and modification to the education provided to include the new BP classification recommendations are warranted. Inclusion of private practice OP clinics in future studies may improve generalizability. Attention to direct and indirect cost associated with this type of educational initiative would be of benefit in future studies. Finally, examination of the impact of prescribed BP-related policy and procedures is warranted to determine whether these variables would have a similar impact on a therapist’s attitudes, practice behaviors, and/or knowledge.

**CONCLUSION**

An educational initiative inclusive of (1) providing BP assessment tools, (2) attending a 1-hour evidence-based BP

---

**TABLE 6**

<table>
<thead>
<tr>
<th>BP Classification Based on Reading</th>
<th>Normal (n = 68)</th>
<th>P-HTN (n = 123)</th>
<th>HTN (n = 68)</th>
<th>Differences in Action by BP Classification (P)</th>
<th>Normal Compared With P-HTN (P)</th>
<th>Normal Compared With HTN (P)</th>
<th>P-HTN Compared With HTN (P = )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist Action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No action taken</td>
<td>37</td>
<td>69</td>
<td>15</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.82</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Informed patient of BP reading</td>
<td>55</td>
<td>89</td>
<td>64</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.19</td>
<td>0.02&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Educated patient on lifestyle modification to optimize BP measurement</td>
<td>2</td>
<td>9</td>
<td>26</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.21</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Engaged in discussion of medication compliance with patient</td>
<td>2</td>
<td>9</td>
<td>39</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.21</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.001&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Called physician and informed of BP findings call</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>0.01&lt;sup&gt;a&lt;/sup&gt;</td>
<td>—</td>
<td>0.08</td>
<td>0.02&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Referred to emergency department for additional medical treatment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Modified the therapy visit on that date</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0.18</td>
<td>.36</td>
<td>1.00</td>
<td>0.13</td>
</tr>
<tr>
<td>Held the therapy visit on that date held</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0.24</td>
<td>1.00</td>
<td>0.50</td>
<td>0.29</td>
</tr>
</tbody>
</table>

<sup>a</sup>Met significance level of P < .05.

BP, blood pressure; HTN, hypertensive; P-HTN, prehypertensive.
lecture, (3) providing a decision-making reference, and (4) a directive to perform valid and reliable BP techniques and interventions for 1 week resulted in significantly positive changes to an OP therapists attitude, immediate practice behavior, and knowledge of BP.

Acknowledgments

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REFERENCES

Rehabilitation provider blood pressure decision-making algorithm

≤139 mmHg systolic and/or ≤ 89 mmHg diastolic

NO HTN diagnosis
- Inform patient of reading
- Lifestyle modification education
- Document blood pressure

HTN diagnosis
- Inform patient of reading
- Lifestyle modification education
- Continue current medication regimen
- Document blood pressure

140-179 mmHg systolic and/or 90-109 mmHg diastolic

NO Symptoms *Wait 5 minutes and recheck
- Inform patient of reading
- Determine medication compliance if appropriate
- Monitor during therapy intervention
- Document blood pressure
- Re-check at next therapy visit
  - If still in abnormal range notify physician
  - If in safe range continue to monitor

Symptoms
- Inform patient of reading
- Determine medication compliance if appropriate
- Contact physician
- Obtain medical clearance prior to initiating exercise
- Document blood pressure

≥ 180 mmHg systolic and/or ≥ 110 mmHg diastolic

NO Symptoms *Wait 5 minutes and recheck
- Inform patient of reading
- Determine medication compliance if appropriate
- Contact physician
- Physician determines next steps
- Hold exercise
- Document blood pressure

Symptoms
- Inform patient of reading
- Determine medication compliance if appropriate
- Contact physician
- Physician determines next steps
- Send to emergency department if unable to contact physician
- Hold exercise
- Document blood pressure