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J Womens Health (Larchmt). Author manuscript; available in PMC 2025 February 14.

Published in final edited form as:

J Womens Health (Larchmt). 2024 April ; 33(4): 467–472. doi:10.1089/jwh.2023.0612.

Women with Blood Pressure Improvement in the Well-Integrated Screening and Evaluation for Women Across the Nation Program by Race and Ethnicity, 2014–2018

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Abstract

Background: The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program aims to improve the cardiovascular health of women aged 40–64 years with low incomes, and who are uninsured or underinsured. The objective is to examine WISEWOMAN participants with hypertension who had high blood pressure (BP) improvement from January 2014 to June 2018, by race and ethnicity. Also examined was participation in WISEWOMAN Healthy Behavior Support Services (HBSS) and adherence to antihypertensive medication.

Materials and Methods: WISEWOMAN data from January 2014 to June 2018 were analyzed by race and ethnicity. BP improvement was defined as at least a 5 mm Hg decrease in systolic or diastolic BP values from baseline screening to rescreening. The prevalence of HBSS participation and antihypertensive medication adherence were calculated among hypertensive women with BP improvement.

Results: Approximately 64.2% (4,984) of WISEWOMAN participants with hypertension had at least a 5 mm Hg BP improvement. These improvements were consistent across each race and ethnicity ($p = 0.56$) in the study. Nearly 70% of women who had BP improvement attended at least one HBSS. Hispanic women (80.1%) had the highest HBSS attendance percentage compared to non-Hispanic Black women (64.1%) and non-Hispanic White women (63.8%; $p < 0.001$). About 80% of women with BP improvement reported being adherent to antihypertensive medication in the previous 7 days.

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Authors' Contributions

All authors made substantial contributions in developing the concept of the article and drafting, revising, and editing the content of the article. Each author approved the final revision of the article.

Disclaimer

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention

Author Disclosure Statement

No competing financial interests exist.

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Conclusions: The proportion of women achieving BP improvement in the WISEWOMAN program was consistent across race and ethnicity. In addition, women with BP improvement reported adherence to antihypertensive medication and participation in HBSS.

Keywords

high blood pressure; blood pressure improvement; WISEWOMAN; Healthy Behavior Support Services; antihypertensive medication adherence; hypertension management; hypertension

Introduction

HIGH BLOOD PRESSURE (BP) is a major public health concern and a primary modifiable risk factor for cardiovascular disease (CVD).[1] The prevalence of high BP or hypertension is known to increase with age; approximately three-fourths of the population aged ≥60 years will develop high BP.[2] High BP is also affected by diet, health behaviors, lifestyle choices, and other modifiable factors.[3,4] Modest improvements in BP values have been shown to help reduce the prevalence of CVD.[1]

A meta-analyses found that decreases in BP can lower the risk of stroke by ~63% and heart failure by 58%; their analysis emphasized that even small reductions in systolic or diastolic BP can lower CVD risk.[5] Another study highlighted that small reductions in BP would improve overall cardiovascular health measures.[6] They estimated that a 5 mm Hg reduction in systolic BP values would reduce the risk of developing cardiovascular events by 10% globally.[6] Researchers estimated 2–5 mm Hg reductions in systolic and diastolic BP in the United States adult population could lead to at least 60% of this population having an ideal BP.[3,6] These researchers also recommended a combination of individual, health system, and population-level approaches to improve cardiovascular health.[3]

Nearly, one-third of women in the United States have hypertension and, among those, less than half have their BP under control.[7] The U.S. Centers for Disease Control and Prevention's (CDC) Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program aims to improve the cardiovascular health of women, aged 40–64 years, with low incomes who are uninsured or underinsured.[8,9] These women receive screenings in diverse rural and urban settings throughout the nation where funded recipients operate WISEWOMAN programs.

The WISEWOMAN program uses six major hypertension management strategies to reduce the risk for CVD, including heart disease and stroke: (1) referring women to healthy behavior support services (HBSS) that are free for WISEWOMAN participants, such as evidence-based lifestyle programs, health coaching, and systematic referrals to community resources such as smoking cessation programs; (2) empowering women to adhere to medications by improving access to low- or no-cost medication; (3) providing women with hypertension a self-measured BP monitoring device with clinical support; (4) using electronic health records to identify women with hypertension, and to assess and manage their condition; (5) arranging medical follow-up for women with very-high BP values (≥180/≥ 110 mm Hg)[10]; and (6) using a team-based care approach for hypertension management constituting of a participant's medical care provider and other clinical health professionals.

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This article is the first report to examine women with BP improvement in the WISEWOMAN population with hypertension, by race and ethnicity. The authors were motivated to analyze equal access for hypertension management among racial and ethnic groups in WISEWOMAN Programs. This report achieves this aim by examining WISEWOMAN participants with hypertension, by race and ethnicity who had BP improvement during the period of January 2014 to June 2018. In addition, the authors examine the participation of women in two of the six WISEWOMAN Program hypertension management strategies, specifically participation in HBSS and adherence to antihypertensive medication.

Materials and Methods

Data were obtained from all 21 WISEWOMAN funded recipients in 19 states and 2 tribal organizations in Alaska. These funded recipients are Alabama, California, Colorado, Connecticut, Illinois, Indiana, Iowa, Michigan, Missouri, Nebraska, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Vermont, West Virginia, Southeast Alaska Regional Health Consortium, and Southcentral Foundation. A descriptive analysis of the WISEWOMAN population with hypertension who had BP improvement was conducted. Baseline heart disease screenings were performed on all WISEWOMAN participants and included BP measurements. HBSS occurs after baseline screening, which is followed by rescreening. Rescreening occurs 11–18 months after baseline screening.[9]

From January 2014 to June 2018, 7761 WISEWOMAN participants aged 40–64 years with hypertension had a baseline screening and rescreening. This analysis was restricted to Hispanic, non-Hispanic Black (NHB) and non-Hispanic White (NHW) women, as these women had the largest representation (89.2%) in the WISEWOMAN population.

The WISEWOMAN program identified women with hypertension based on the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure standards (JNC7).[11] A woman with hypertension met at least one of the following three criteria: (1) responded “Yes” when asked at baseline screening or rescreening (screening visit), “Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?”; (2) responded “Yes” when asked, “Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high blood pressure?”; or (3) had an average systolic BP ≥140 mmHg or diastolic BP ≥90 mmHg based on two BP readings at the time of a screening. BP was measured in a clinical setting by medical professionals.

In this analysis, authors defined BP improvement in women with hypertension as having at least a 5 mm Hg decrease in systolic or diastolic BP between baseline screening and rescreening.[5,12] The WISEWOMAN program defined antihypertensive medication adherence as taking medication seven out of 7 days in the previous week, based on the question: “During the past 7 days, how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?.” In addition, there were women who had no history of being prescribed medication because they responded “No” or had no response to the question, “Was medication prescribed to lower blood pressure?.” In

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addition, women who attended at least one session of HBSS after baseline screening were identified. This analysis assessed improvement in BP, medication adherence, and HBSS participation by race and ethnicity.

The analysis focused on two of the six WISEWOMAN hypertension management strategies —participation in HBSS and adherence to antihypertensive medication—because these strategies have quantitative data that can readily be analyzed. Women participate in HBSS, which is offered by providers in the formats of Health Coaching and Lifestyle Programs. Health Coaching is generally offered in three sessions that are spaced apart, while Lifestyles Programs have their own curriculum and number of sessions offered over time. Participation in HBSS is recorded by the number of sessions. For this article, women who had attended one or more HBSS sessions were examined.

Adherence to antihypertensive medication is recorded by asking: “During the past 7 days, how many days did you take prescribed medication for high blood pressure (0–7 days).” Medication adherence was defined as taking medication daily. CDC previously determined that WISEWOMAN is a public health practice program and does not conduct human subject research.

Statistical analysis

Median age of participants was provided by race and ethnicity. Also, the percentage of WISEWOMAN participants with hypertension and BP improvement among those with hypertension was calculated. Among those with BP improvement, we calculated the prevalence of HBSS attendance and medication adherence status. Univariate chi-square tests of independence were conducted for BP improvement outcomes by race and ethnicity. Significance was determined at $p < 0.05$. SAS software 9.4 (SAS Institute) was used for the analyses.[13]

Results

The median age of participants was 55 years and was similar across groups by race and ethnicity (54 among Hispanic women, 55 among NHB women, and 56 years among NHW women). There were 7,761 women with hypertension who were Hispanic (35.5%), NHB (24.3%), and NHW Women (40.2%) with both baseline screenings and rescreenings (Table 1). Of these WISEWOMAN participants, 4,984 (64.2%) had (≥5 mm Hg) BP improvement in the WISEWOMAN program. The percentages of women with BP improvement were similar across race and ethnicity among Hispanic, NHB, and NHW women (63.4%, 64.8%, 64.6%, respectively; $p = 0.56$; Table 1). Nearly, 70% percent of women with at least a 5 mm Hg BP improvement attended at least one HBSS. Among those with BP improvement, Hispanic women had the highest percentage of HBSS attendance (80.1% attended at least one session) followed by NHB (64.1%) and NHW (63.8%) women ($p < 0.001$; Table 1).

Approximately 80% or 4,006 hypertensive women with BP improvement, reported being adherent to antihypertensive medication in the last 7 days (Table 2). The prevalence of antihypertensive medication adherence was 75.9% for Hispanic women, 85.5% for NHB women, and 81.1% for NHW women ($p < 0.001$) (Table 2). There were 472 (9.5%) women

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with BP improvement who either reported that they were not prescribed medication or did not provide information about being prescribed hypertension medication (Table 2). Of these women, 340 (72%) had attended at least one HBSS and 208 (44.1%) had attended three or more HBSS. Of the 340 women with blood pressure improvement who were not prescribed medication, 208 (61.2%) attended three or more HBSS (Table 3).

Discussion

Overall, approximately three in five women with hypertension in the WISEWOMAN program showed BP improvement. As noted previously, all participants in the WISEWOMAN program are uninsured and underinsured women who opt into the program to receive services they would have not otherwise received, regardless of their race and ethnicity. A study observed that persons who use free clinics generally earn low income, or they are unemployed, women, and/or minorities.[14] They also observed that patients using free clinics are generally sicker than other patient populations.[14] A previous study reported that 96% of women with hypertension in the WISEWOMAN program had at least one other chronic condition.[10]

To manage high BP and thereby reduce the risk of CVD, the scientific literature supports use of multilevel and multicomponent strategies,[12] which combine clinician and patient-level input within a team-based care setting. In team-based care, staff with diverse skills share duties related to a patient's cardiovascular health. A study reported in its meta-analysis that pharmacist- and nurse-led interventions produced greater reductions in BP than traditional care models.[12]

This report highlights that HBSS attendance is a key component of WISEWOMAN hypertension management strategies. Results of a meta-analysis concluded that patient-level strategies, including health coaching, led to a significant decrease in systolic BP.[12] These patient-level strategies in WISEWOMAN include participation in lifestyle change programs or health coaching. HBSS provide information that women can use to help reduce heart disease risk factors. These services are also successful when aligned with cultural preferences and community resources to assist women with healthy lifestyle changes.[9] Some healthy lifestyle modifications that favorably affect hypertension include increased physical activity, smoking cessation, and improved nutrition with emphasis on lowering sodium intake.[15] In the WISEWOMAN program, health coaching sessions are culturally and linguistically tailored to Hispanic women, aligning them with their cultural preferences and resources in their community for healthy lifestyle modifications.

Empowering women to adhere to medication can also help reduce high BP.[16] In this study, women with improved BP values adhered to antihypertensive medication; NHB women had the highest adherence to antihypertensive medication compared to Hispanic women and NHW women. Reducing the cost of medicine is another strategy to reduce BP. The Community Preventive Services Task Force suggests that lowering the cost of medications can help control BP and produce better clinical outcomes by improving medication adherence.[17] In WISEWOMAN, this is accomplished through improving access to low- or no-cost medication. WISEWOMAN programs use a variety of approaches to

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support medication adherence, including health coaching, dose adjustments, medication reminder systems, and access to pharmacist counseling. This recommendation to lower the cost of antihypertensive medication is supported by CDC's Division for Heart Disease and Stroke Prevention's resource guide, Best Practices for Cardiovascular Disease Prevention Programs.[18]

This study has implications for public health practice. A strength of this analysis is that it reinforces the positive impact of patient-level strategies to reduce hypertension. Our analysis also found that tailoring programs, as necessary and within the context of unique populations, is a critical component of lowering risk for CVD. Future studies may examine the contribution of independent association of each WISEWOMAN hypertension management strategy to reducing CVD risk in the WISEWOMAN program.

Limitations

This analysis was reflective of a public health practice program; therefore, the authors are limited to reporting changes in the population who chose to participate in the program and return for an additional screening. Women who did not return for an additional screening were excluded from the study. Furthermore, as this was a 5-year program, some women may have aged out of, or lost their eligibility for the program. Since WISEWOMAN is a public health practice program, it reflects a very specific population and is not generalizable to the U.S. population.

As all WISEWOMAN participants were uninsured or underinsured, participants may not have been able to return for an additional screening for various reasons. Overall, this loss to follow-up may introduce bias in the analysis. Some women often face socioeconomic barriers that can impede access to services to reduce heart disease risk, such as transportation limitations or conflicting family responsibilities.[14] Despite funded recipients' best efforts toward addressing these barriers, women still experience continuing challenges.

Additional limitations included potential measurement errors at the clinical level that could lead to misclassification. WISEWOMAN Program does not have access to clinical notes regarding participant treatment for hypertension. Measuring BP values for some women may have resulted in white coat or masked hypertension. Also, some of the data collected, such as adherence to antihypertensive medication, were self-reported values and were reliant on the accuracy of those responses. Despite these limitations, this report provides valuable information about the management of BP within WISEWOMAN and its broader implication of applying these strategies in public health practice.

Conclusions

The proportion of women achieving BP improvement in the WISEWOMAN program was consistent across race and ethnicity as the analysis showed at least a 5 mm Hg decrease in high BP. In addition, women with BP improvement reported adherence to antihypertensive medication and participation in HBSS, which are two hypertension management strategies. The approach to these hypertension management strategies can be tailored among racial

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and ethnic groups in WISEWOMAN Programs as Hispanics and NHB populations had the highest HBSS attendance and antihypertensive medication adherence, respectively.

Acknowledgment

The authors thank Diane Manheim, MSW, Cathleen Gillespie, MS, and Mary George, MD, MSPH for their valuable insights.

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Summary

What is already known on this topic?

Nearly one-third of women in the United States have hypertension and, among those, less than half have their blood pressure (BP) under control. A 5 mm Hg reduction in BP in an adult population could substantially reduce the overall burden of high BP. The WISEWOMAN Program serves uninsured and underinsured women and aims to improve the cardiovascular health of women with low incomes, who are aged 40–64 years.

What is added by this report?

1. Women with BP improvement showed at least a 5 mm Hg decrease in high BP by race and ethnicity in WISEWOMAN Programs.
2. Women with BP improvement reported adherence to antihypertensive medication and participation in Health Behavior Support Services, which are two hypertension management strategies in WISEWOMAN Programs.

What are the implications for public health practice?

1. Practitioners and public health professionals can use these findings to reinforce hypertension management strategies in women, as managing hypertension is critical to lowering risk for cardiovascular disease.
2. These BP management strategies may be tailored to specific racial and ethnic populations, as hypertension is a priority public health issue.

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Table 1:

Median Ages and Percentages of Women Aged 40–64 Years With Hypertension, Who Had ≥5 mm Hg Improvement in Blood Pressure Values and Those Who Attended Healthy Behavior Support Services, WISEWOMAN 2014–2018, by Race and Ethnicity

Women by Race and Ethnicity	Median Age (Women 40–64 years old)	Women With Hypertension[a]		Women With Hypertension and at least 5 mm Hg Improvement in Blood Pressure Values			Women With Hypertension and at least 5 mm Hg Improvement in Blood Pressure Values Who Attended at Least 1 HBSS[c]		
		Number	Percent of Total	Number	Percent[b]	χ^2[e]	Number	Percent[d]	χ^2[e]
All	55	7,761	100.0	4,984	64.2	-	3,468	69.6	-
Hispanic	54	2,757	35.5	1,749	63.4	0.56	1,400	80.1	<.001
Non-Hispanic Black	55	1,883	24.3	1,220	64.8		782	64.1	
Non-Hispanic White	56	3,121	40.2	2,015	64.6		1,286	63.8	

[a] Hypertension was defined as responding 1) "YES" to "have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?" at baseline screening or rescreening; 2) responding "YES" when asked, "Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high blood pressure?"; or 3) had an average systolic BP ≥140 mm Hg or diastolic BP ≥90 mm Hg, based on 2 BP readings at the time of the screening visit

[b] Percent among women with hypertension.

[c] Healthy Behavior Support Services

[d] Percent among women with hypertension and ≥5 mm Hg improvement in systolic or diastolic BP between baseline and rescreening.

[e] Chi-square test of independence for race and ethnicity.

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Table 2:

Percentages of Women, Aged 40–64 Years, With Hypertension[a] with Improvement in Blood Pressure Values[b] and Adherent to Medication, Women Not Adherent to Medication, and Those Not Prescribed Medication, WISEWOMAN 2014–2018, by Race and Ethnicity

Women Race and Ethnicity	Women Adherent to Medication[c]			Women Not Adherent to Medication			Women Not Prescribed Medication[d]		
	Number	Percent	χ^2[e]	Number	Percent	χ^2[e]	Number	Percent	χ^2[e]
All	4,006	80.4		506	10.2		472	9.5	-
Hispanic	1,328	75.9	<.001	223	12.8	<.001	198	11.3	<.001
Non-Hispanic Black	1,043	85.5		118	9.7		59	4.8	
Non-Hispanic White	1,635	81.1		165	8.2		215	10.7	

[a]Hypertension was defined as 1) responding “YES” to “have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?” at baseline screening or rescreening; 2) responding “YES” when asked, “Are you taking any medicine prescribed by your doctor, nurse, or other health professional for your high blood pressure?”; or 3) had an average systolic BP ≥140 mm Hg or diastolic BP ≥90 mm Hg, based on 2 BP readings at the time of the screening visit

[b]Among women with hypertension and 5 mm Hg improvement in systolic or diastolic BP between baseline and rescreening.

[c]Medication Adherence is defined as a participant reporting taking hypertension medication daily (seven out of 7 days).

[d]Represent women who had no record of being prescribed hypertension medication

[e]Race and ethnicity distributions were statistically significant at $p < 0.001$. Chi square test.

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Table 3:

Total Number of Healthy Behavior Support Services Attended by Women, Aged 40–64 Years, With Blood Pressure Improvement, Who Were Not Prescribed Medication, WISEWOMAN 2014–2018

Number of HBSS Attended	Women Who Attended HBSS	
	Number	Percent
Total	340	100.0
1	78	22.9
2	54	16.0
3^{+}	208	61.2

Three-hundred forty (72%) attended at least one HBSS

HBSS, health behavior support services.