Health Communication

CHAPTER 11

Lead Agency

Office of Disease Prevention and Health Promotion

Contents

GOAL:
Use communication strategically to improve health.

The objectives in this chapter monitor the availability of Internet access, health literacy, and the characteristics of health communication campaigns and health-related websites. The number of Centers for Excellence in Health Communication and patient perception of health provider communication skills are also tracked.

All Healthy People tracking data quoted in this chapter, along with technical information and Operational Definitions for each objective, can be found in the Healthy People 2010 database, DATA2010, available from http://wonder.cdc.gov/data2010/.

More information about this focus area can be found in the following publications:

- *Healthy People 2010: Understanding and Improving Health*, available from http://www.healthypeople.gov/2010/Document/tableofcontents.htm#under.
- *Healthy People 2010 Midcourse Review*, available from http://www.healthypeople.gov/2010/data/midcourse/html/default.htm#FocusAreas.

Highlights

- Substantial progress was achieved in objectives for this Focus Area during the past decade [1]. Fourteen of the 16 Health Communication objectives with data to measure progress moved toward or achieved their Healthy People 2010 targets (Figure 11-1). However, health disparities of 10% or more were observed for a number of population groups (Figure 11-2), as highlighted below [2].
- The proportion of adults with Internet access at home (objective 11-1) increased 165.4% between 1998 and 2009, from 26% to 69%, moving toward the Healthy People 2010 target of 80%.
  - Among racial and ethnic groups, the Asian population had the highest (best) rate of Internet access at home, 80% in 2009, whereas the American Indian or Alaska Native, Hispanic or Latino, and non-Hispanic black populations each had a rate of 53%. When expressed as persons *without* Internet access at home, the rates for these three populations were almost two and a half times the rate for the Asian population [2].
  - Among education groups, persons with at least some college education had the highest (best) rates of Internet access at home, 31% in 1998 and 82% in 2009, whereas high school graduates had rates of 16% in 1998 and 57% in 2009, and persons with less than a high school education had rates of 5% in 1998 and 32% in 2009.
    - In 2009, when expressed as persons *without* Internet access at home, the rate for high school graduates was almost two and a half times the rate for persons with at least some college education, whereas the rate for persons with less than a high school education was nearly four times that rate [2].
    - Between 1998 and 2009, the disparity between high school graduates and persons with at least some college education increased 117 percentage points, whereas the disparity between persons with less than a high school education and those with at least some college education increased 240 percentage points [3].
- Internet access at home varied by geographic area. In 2009, the proportion of adults with Internet access at home was highest in the states of Alaska, Connecticut, Massachusetts, New Hampshire, New Jersey, Oregon, Utah, and Washington. The states with the lowest proportion of adults with Internet access at home were Alabama, Arkansas, Mississippi, and South Carolina (Figure 11-3).
- The proportion of health websites disclosing information that could be used to assess the quality

of the site (objectives 11-4a through g) increased for all categories. The Healthy People 2010 targets were exceeded for four objectives:

- The proportion of websites that disclosed their purpose, uses, and limitations (objective 11-4b) increased 20.0% between 2006 and 2009, from 35% to 42%, exceeding the target of 40%.
- The proportion of websites that disclosed their privacy policies (objective 11-4d) increased 13.3% between 2006 and 2009, from 75% to 85%, exceeding the target of 80%.
- The proportion of websites that provided user feedback options (objective 11-4e) increased 49.2% between 2006 and 2009, from 59% to 88%, exceeding the target of 64%.
- The proportion of websites that met at least three of the six disclosure criteria (objective 11-4g) increased 116.7% between 2006 and 2009, from 24% to 52%, exceeding the target of 29%.

› Health disparities of 100% or more in the proportion of persons with below-basic health literacy skills (objective 11-2b) were observed for a number of population groups:

- Among racial and ethnic groups, the non-Hispanic white population had the lowest (best) rate of persons with below-basic health literacy, 9% in 2003, whereas the non-Hispanic black, American Indian or Alaska Native, and Hispanic or Latino populations had rates of 24%, 25%, and 41%, respectively. The rate for the non-Hispanic black population was more than two and a half times the best rate (that for the non-Hispanic white population); the rate for the American Indian or Alaska Native population was almost three times the best rate; and the rate for the Hispanic or Latino population was more than four and a half times the best rate [2].
- Among education groups, persons with at least some college education had the lowest (best) rate of persons with below-basic health literacy, 5% in 2003. High school graduates and persons with less than a high school education had rates of 15% and 54%, respectively. The rate for high school graduates was three times the best group rate (that for persons with at least some college education), whereas the rate for persons with less than a high school education was nearly 11 times the best group rate [2].
- Persons without disabilities had a lower (better) rate of persons with below-basic health literacy than persons with disabilities, 10% in 2003. The rate for persons with disabilities was 23%, nearly two and a half times the rate for persons without disabilities [2].

Summary of Progress

› Figure 11-1 presents a quantitative assessment of progress in achieving the Healthy People 2010 objectives for Health Communication. Data to measure progress toward target attainment were available for 16 objectives [1]. Of these:

- Five objectives (11-4b, d, e, and g; and 11-5) exceeded the Healthy People 2010 targets.
- Nine objectives moved toward their targets. A statistically significant difference between the baseline and the final data points was observed for six of these objectives (11-1; 11-4c and f; and 11-6a, c, and d). No significant differences were observed for two objectives (11-4a and 11-6b); and data to test the significance of the difference were unavailable for one objective (11-3c).
- Two objectives moved away from their targets (objectives 11-3a and b). Data to test the significance of the difference between the baseline and the final data points were unavailable for either of these objectives.

› Follow-up data were unavailable to measure progress for two objectives (11-2a and b).

› Figure 11-2 displays health disparities in Health Communication from the best group rate for each characteristic at the most recent data point [2]. It also displays changes in disparities from baseline to the most recent data point [3].

- Of the seven objectives with statistically significant racial and ethnic health disparities of 10% or more, the non-Hispanic black population had the best rate for four objectives (11-6a through d). The Asian population had the best rate for two objectives (11-1 and 11-2b), and the non-Hispanic white population had the best rate for one objective (11-2b).
- Males had better rates than females for two of the three objectives with statistically significant health disparities of 10% or more by sex (objectives 11-1 and 11-6a). Females had a better rate for objective 11-2b.
- Of the seven objectives with statistically significant health disparities of 10% or more by education level, high school graduates had the best rate for three objectives (11-6a, c, and d), and persons with at least some college education also had the best rate for three objectives (11-1a, and 11-2a and b). The population of high school graduates and the population of persons with at least some college education both had the best group rate for one objective (persons reporting that their health care providers explained things so they could understand, objective 11-6b).

- Residents of urban or metropolitan areas had a better group rate for the one objective with statistically significant health disparities of 10% or more by geographic location (persons with Internet access at home; objective 11-1).
- Persons without disabilities had a better group rate for all three objectives with statistically significant health disparities of 10% or more by disability status (objectives 11-2b, and 11-6b and c).
- As discussed in the Highlights, above, health disparities of 100% or more were observed for two objectives (11-1 and 11-2b). Changes in health disparities of 100 percentage points or more were observed for one objective (11-1).

Transition to Healthy People 2020

For Healthy People 2020, the focus of the Health Communication and Health Information Technology (IT) Topic Area has been expanded to include more objectives that are shaped by the communication processes and the information technology that people interact with every day. The Healthy People 2010 Focus Area name was changed from Health Communication to Health Communication and Health IT to strategically combine health IT tools and effective health communication processes. See HealthyPeople.gov for a complete list of Healthy People 2020 topics and objectives.

The Healthy People 2020 Health Communication and Health IT objectives are geared toward:

- Providing personalized self-management tools and resources
- Building social support networks
- Delivering accurate, accessible, and actionable health information that is targeted or tailored
- Facilitating the meaningful use of health IT and exchange of health information among health care and public health professionals
- Enabling quick and informed response to health risks and public health emergencies
- Increasing health literacy skills
- Providing new opportunities to connect with culturally diverse and hard-to-reach populations
- Providing a trained workforce for the design of programs and interventions that result in healthier behaviors
- Increasing Internet and mobile access.

The differences between the Healthy People 2010 and Healthy People 2020 objectives are summarized below:

- The Healthy People 2020 Health Communication and Health IT Topic Area has a total of 24 objectives, 10 of which are developmental, whereas the Healthy People 2010 Health Communication Focus Area had 18 objectives [4].
- Four Healthy People 2010 objectives were retained "as is" [5]. These objectives address patient reports of health care provider communication skills (objectives 11-6a through d).
- Two Healthy People 2010 objectives were modified [6]. These objectives include Internet access at home (objective 11-1) and health websites that disclose at least three criteria (objective 11-4g) [6].
- Twelve Healthy People 2010 objectives were archived [7]. These objectives include: persons with proficient health literacy (objective 11-2a); persons with below basic health literacy (objective 11-2b); health communication campaigns sponsored by the Department of Health and Human Services (DHHS) that include formative evaluation (objective 11-3a); health communication campaigns sponsored by DHHS that include process evaluation (objective 11-3b); health communication campaigns sponsored by DHHS that include outcome evaluation (objective 11-3c); health websites that disclose the identity of the responsible persons or organizations (objective 11-4a); health websites that disclose the purpose, uses, and limitations of the sites (objective 11-4b); health websites that disclose content development practices and policies on the sites (objective 11-4c); health websites that disclose privacy policy and protection on the sites (objective 11-4d); health websites that disclose user feedback and evaluation on the sites (objective 11-4e); health websites that disclose content creation on the sites (objective 11-4f); and the number of Centers for Excellence in Health Communication (objective 11-5).
- Seventeen new objectives were added to the Healthy People 2020 Topic Area:
  - Three new health literacy objectives monitor the proportion of persons who report that their health care provider always provides them with easy-to-understand instructions about how to address their illness or health condition; that their health care provider always asks them to describe how they will follow the instructions; and that their health care provider's office always offers help with filling out a form.
  - Three new social marketing objectives track the proportion of state health departments using

social marketing in health promotion and disease prevention programs; schools of public health and accredited master of public health (MPH) programs that offer one or more courses in social marketing; and schools of public health and accredited MPH programs that offer workforce development activities in social marketing for public health practitioners.

- Two new Internet access objectives track the proportion of persons with broadband access to the Internet and the proportion of persons who use mobile devices.
- Two new electronic personal health management tools objectives target the proportion of persons who use the Internet to keep track of personal health information, such as care received, test results, or upcoming medical appointments; and persons who use the Internet to communicate with their provider.
- The remaining seven new objectives track the proportion of:
  - Persons who report that their health care providers always involve them in decisions about their health care as much as they want
  - Patients whose doctor recommends personalized health information resources to help them manage their health
  - Adults who report having friends or family members whom they talk with about their health
  - Online health information seekers who report easily accessing health information
  - Medical practices that use electronic health records
  - Meaningful users of health IT
  - Crisis and emergency risk messages intended to protect the public's health that demonstrate the use of best practices.

The Healthy People 2020 objectives continue to reflect the importance of the use of health communication strategies and health IT to improve population health outcomes and health care quality, and to achieve health equity. For objectives that were archived, DHHS and the agencies that serve as the leads for the Healthy People 2020 initiative will consider ways to ensure that these public health issues retain prominence.

Appendix D, "A Crosswalk Between Objectives From Healthy People 2010 to Healthy People 2020," summarizes the changes between the two decades of objectives, reflecting new knowledge and direction for this area.

Data Considerations

In general, data on educational attainment are presented for persons aged 25 and over, consistent with guidance given by the Census Bureau. However, because of the requirements of the different data systems, the age groups used to calculate educational attainment for any specific objective may differ from the age groups used to report the data for other Healthy People 2010 objectives, as well as from select populations within the same objective. Therefore, the reader is urged to exercise caution in interpreting the data by educational attainment shown in the Health Disparities Table. See *Healthy People 2010: General Data Issues*, referenced below.

Additional information on data issues is available from the following sources:

- All Healthy People 2010 tracking data can be found in the Healthy People 2010 database, DATA2010, available from http://wonder.cdc.gov/data2010/.
- Detailed information about the data and data sources used to support these objectives can be found in the Operational Definitions on the DATA 2010 website, available from http://wonder.cdc.gov/data2010/focusod.htm.
- More information on statistical issues related to Healthy People tracking and measurement can be found in the Technical Appendix and in *Healthy People 2010: General Data Issues*, which is available in the General Data Issues section of the NCHS Healthy People website under Healthy People 2010; see http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_data_issues.htm.

Notes

1. Displayed in the Progress Chart (Figure 11-1), the percent of targeted change achieved expresses the difference between the baseline and the final value relative to the initial difference between the baseline and the Healthy People 2010 target. As such, it is a relative measure of progress toward attaining the Healthy People 2010 target. See the Reader's Guide for more information. When standard errors were available, the difference between the baseline and the final value was tested at the 0.05 level of significance. See the Figure 11-1 footnotes, as well as the Technical Appendix, for more detail.
2. Information about disparities among select populations is shown in the Health Disparities Table

(Figure 11-2). Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic. For example, racial and ethnic health disparities are measured as the percent difference between the best racial and ethnic group rate and each of the other racial and ethnic group rates. Similarly, disparities by sex are measured as the percent difference between the better group rate (e.g., female) and the rate for the other group (e.g., male). Some objectives are expressed in terms of favorable events or conditions that are to be increased, while others are expressed in terms of adverse events or conditions that are to be reduced. To facilitate comparison of health disparities across different objectives, disparity is measured only in terms of adverse events or conditions. For comparability across objectives, objectives that are expressed in terms of favorable events or conditions are re-expressed using the adverse event or condition for the purpose of computing disparity, but they are not otherwise restated or changed. For example, objective 1-1, to increase the proportion of persons with health insurance (e.g., 72% of the American Indian or Alaska Native population under age 65 had some form of health insurance in 2008), is expressed in terms of the percentage of persons without health insurance (e.g., 100% – 72% = 28% of the American Indian or Alaska Native population under age 65 did not have any form of health insurance in 2008) when the disparity from the best group rate is calculated. See the Reader's Guide for more information. When standard errors were available, the difference between the best group rate and each of the other group rates was tested at the 0.05 level of significance. See the Figure 11-2 footnotes, as well as the Technical Appendix, for more detail.

3. The change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point and, therefore, is expressed in percentage points. See the Reader's Guide for more information. When standard errors were available, the change in disparity was tested at the 0.05 level of significance. See the Figure 11-2 footnotes, as well as the Technical Appendix, for more detail.

4. To be included in Healthy People 2010, an objective must have a national data source that provides a baseline and at least one additional data point for tracking progress. Some objectives lacked baseline data at the time of their development but had a potential data source and were considered of sufficient national importance to be included in Healthy People. These are called "developmental" objectives. When data become available, a developmental objective is moved to measurable status and a Healthy People target can be set.

5. As of the Healthy People 2020 launch, Healthy People 2020 objectives that were retained "as is" from Healthy People 2010 had no change in the numerator or denominator definitions, the data source(s), or the data collection methodology. These include objectives that were developmental in Healthy People 2010 and are developmental in Healthy People 2020, and for which no numerator information is available.

6. As of the Healthy People 2020 launch, objectives that were modified from Healthy People 2010 had some change in the numerator or denominator definitions, the data source(s), or the data collection methodology. These include objectives that went from developmental in Healthy People 2010 to measurable in Healthy People 2020, or vice versa.

7. Archived objectives had at least one data point in Healthy People 2010 but were not carried forward into Healthy People 2020.

Comprehensive Summary of Objectives: Health Communication

Objective	Description	Data Source
11-1	Persons with Internet access at home (18+ years)	Internet Use Supplement to the Current Population Survey (CPS): Department of Commerce, Census Bureau; Department of Labor (DOL), Bureau of Labor Statistics (BLS).
11-2a	Persons with proficient health literacy (16+ years)	National Assessment of Health Literacy (NAAL), Department of Education, National Center for Education Statistics (NCES).
11-2b	Persons with below-basic health literacy (16+ years)	National Assessment of Health Literacy (NAAL), Department of Education, National Center for Education Statistics (NCES).
11-3a	DHHS-sponsored health communication campaigns that include formative evaluation	DHHS, Office of Disease Prevention and Health Promotion.
11-3b	DHHS-sponsored health communication campaigns that include process evaluation	DHHS, Office of Disease Prevention and Health Promotion.
11-3c	DHHS-sponsored health communication campaigns that include outcome evaluation	DHHS, Office of Disease Prevention and Health Promotion.
11-4a	Health websites that disclose identity of responsible persons/ organization	DHHS, Office of Disease Prevention and Health Promotion.
11-4b	Health websites that disclose purpose/uses/limitations	DHHS, Office of Disease Prevention and Health Promotion.
11-4c	Health websites that disclose content development practices/ policies	DHHS, Office of Disease Prevention and Health Promotion.
11-4d	Health websites that disclose privacy policy/protection	DHHS, Office of Disease Prevention and Health Promotion.
11-4e	Health websites that disclose user feedback/evaluation	DHHS, Office of Disease Prevention and Health Promotion.
11-4f	Health websites that disclose content creation/updating	DHHS, Office of Disease Prevention and Health Promotion.
11-4g	Health websites that disclose three or more of the above criteria	DHHS, Office of Disease Prevention and Health Promotion.
11-5	Centers for Excellence in Health Communication	NIH, NCI.
11-6a	Patients reporting that doctors or other health providers always listen carefully to them (18+ years)	Medical Expenditure Panel Survey (MEPS), AHRQ.
11-6b	Patients reporting that doctors or other health providers always explain things so they can understand (18+ years)	Medical Expenditure Panel Survey (MEPS), AHRQ.
11-6c	Patients reporting that doctors or other health providers always show respect for what they have to say (18+ years)	Medical Expenditure Panel Survey (MEPS), AHRQ.
11-6d	Patients reporting that doctors or other health providers always spend enough time with them (18+ years)	Medical Expenditure Panel Survey (MEPS), AHRQ.

Figure 11-1. Progress Toward Target Attainment for Focus Area 11: Health Communication

LEGEND — Moved away from target[1] | Moved toward target | Met or exceeded target

Objective	Percent of targeted change achieved[2] (0 25 50 75 100)	2010 Target	Baseline (Year)	Final (Year)	Baseline vs. Final: Difference[3]	Baseline vs. Final: Statistically Significant[4]	Baseline vs. Final: Percent Change[5]
11-1. Persons with Internet access at home (18+ years)	79.6%	80%	26% (1998)	69% (2009)	43	Yes	165.4%
11-3. DHHS-sponsored health communication campaigns that include							
a. Formative evaluation		100%	95% (2005)	80% (2009)	-15	Not tested	-15.8%
b. Process evaluation		89%	81% (2005)	68% (2009)	-13	Not tested	-16.0%
c. Outcome evaluation	83.3%	65%	59% (2005)	64% (2009)	5	Not tested	8.5%
11-4. Health websites that disclose							
a. Identity (responsible persons/organization)[6]	22.2%	19%	10% (2006)	12% (2009)	2	No	20.0%
b. Purpose/uses/limitations	140.0%	40%	35% (2006)	42% (2009)	7	No	20.0%
c. Content development practices/policies[6]	33.3%	10%	1% (2006)	4% (2009)	3	Yes	300.0%
d. Privacy policy/protection	200.0%	80%	75% (2006)	85% (2009)	10	No	13.3%
e. User feedback/evaluation	580.0%	64%	59% (2006)	88% (2009)	29	Yes	49.2%
f. Content creation/updating[6]	66.7%	10%	1% (2006)	7% (2009)	6	Yes	600.0%
g. Three or more of the above criteria	560.0%	29%	24% (2006)	52% (2009)	28	Not tested	116.7%
11-5. Centers for Excellence in Health Communication	200.0%	6	4 (2003)	8 (2006)	4	Not tested	100.0%
11-6. Patients (18+ years) reporting that doctors or other health providers always							
a. Listen carefully to them	25.0%	65%	57% (2000)	59% (2007)	2	Yes	3.5%
b. Explain things so they can understand	14.3%	66%	59% (2000)	60% (2007)	1	No	1.7%
c. Show respect for what they have to say	42.9%	66%	59% (2000)	62% (2007)	3	Yes	5.1%
d. Spend enough time with them	42.9%	53%	46% (2000)	49% (2007)	3	Yes	6.5%

Figure 11-1. Progress Toward Target Attainment for Focus Area 11: Health Communication (continued)

NOTES

See the Reader's Guide for more information on how to read this figure. See DATA2010 at http://wonder.cdc.gov/data2010 for all HealthyPeople 2010 tracking data. Tracking data are not available for objectives 11-2a and 11-2b.

FOOTNOTES

[1] Movement away from target is not quantified using the percent of targeted change achieved. See Technical Appendix for more information.

[2] Percent of targeted change achieved = $\frac{\text{Final value} - \text{Baseline value}}{\text{Healthy People 2010 target} - \text{Baseline value}} \times 100$.

[3] Difference = Final value – Baseline value. Differences between percents (%) are measured in percentage points.

[4] When estimates of variability are available, the statistical significance of the difference between the final value and the baseline value is assessed at the 0.05 level. See Technical Appendix for more information.

[5] Percent change = $\frac{\text{Final value} - \text{Baseline value}}{\text{Baseline value}} \times 100$.

[6] Baseline data are statistically unreliable. Values are shown to allow assessment of full criteria set. Refer to Operational Definition for more information.

DATA SOURCES

11-1.	Internet Use Supplement to the Current Population Survey (CPS): Department of Commerce, Census Bureau; Department of Labor (DOL), Bureau of Labor Statistics (BLS).
11-3a–c.	DHHS, Office of Disease Prevention and Health Promotion.
11-4a–g.	DHHS, Office of Disease Prevention and Health Promotion.
11-5.	NIH, NCI.
11-6a–d.	Medical Expenditure Panel Survey (MEPS), AHRQ.

Figure 11-2. Health Disparities Table for Focus Area 11: Health Communication

Disparities from the best group rate for each characteristic at the most recent data point and changes in disparity from the baseline to the most recent data point.

NOTES

See DATA2010 at http://wonder.cdc.gov/data2010 for all Healthy People 2010 tracking data. Disparity data are either unavailable or not applicable for objectives 11-3a through c, 11-4a through g, and 11-5.

Years in parentheses represent the baseline and most recent data years (if available).

Disparity from the best group rate is defined as the percent difference between the best group rate and each of the other group rates for a characteristic (e.g., race and ethnicity). The summary index is the average of these percent differences for a characteristic. Change in disparity is estimated by subtracting the disparity at baseline from the disparity at the most recent data point. Change in the summary index is estimated by subtracting the summary index at baseline from the summary index at the most recent data point. See Technical Appendix for more information.

Measures of variability were available for all the objectives in this table. Thus, the variability of best group rates was assessed, and statistical significance was tested. Disparities of 10% or more are displayed when the differences from the best group rate are statistically significant at the 0.05 level. Changes in disparities over time are indicated by arrows when the changes are greater than or equal to 10 percentage points and are statistically significant at the 0.05 level. See Technical Appendix.

Figure 11-2. Health Disparities Table for Focus Area 11: Health Communication (continued)

LEGEND

The "best" group rate at the most recent data point.

B — The group with the best rate for specified characteristic.

b — Most favorable group rate for specified characteristic, but reliability criterion not met.

Reliability criterion for best group rate not met, or data available for only one group.

Percent difference from the best group rate

Disparity from the best group rate at the most recent data point.

Less than 10%, or difference not statistically significant (when estimates of variability are available).

10%–49%

50%–99%

100% or more

Changes in disparity over time are shown when: (a) disparities data are available at both baseline and most recent time points; (b) data are not for the group(s) indicated by "B" or "b" at either time point; and (c) the change is greater than or equal to 10 percentage points and statistically significant, or when the change is greater than or equal to 10 percentage points and estimates of variability were not available. See Technical Appendix.

Increase in disparity (percentage points)

↑ 10–49 points

↑↑ 50–99 points

↑↑↑ 100 points or more

Decrease in disparity (percentage points)

↓ 10–49 points

↓↓ 50–99 points

↓↓↓ 100 points or more

Availability of Data

Data not available.

Characteristic not selected for this objective.

FOOTNOTES

[1] Baseline data by race and ethnicity are for 2002.

[2] Most recent data by disability status are for 2004.

[i] The group with the best rate at the most recent data point is different from the group with the best rate at baseline. Both rates met the reliability criterion. See Technical Appendix.

[ii] Change in the summary index cannot be assessed. See Technical Appendix.

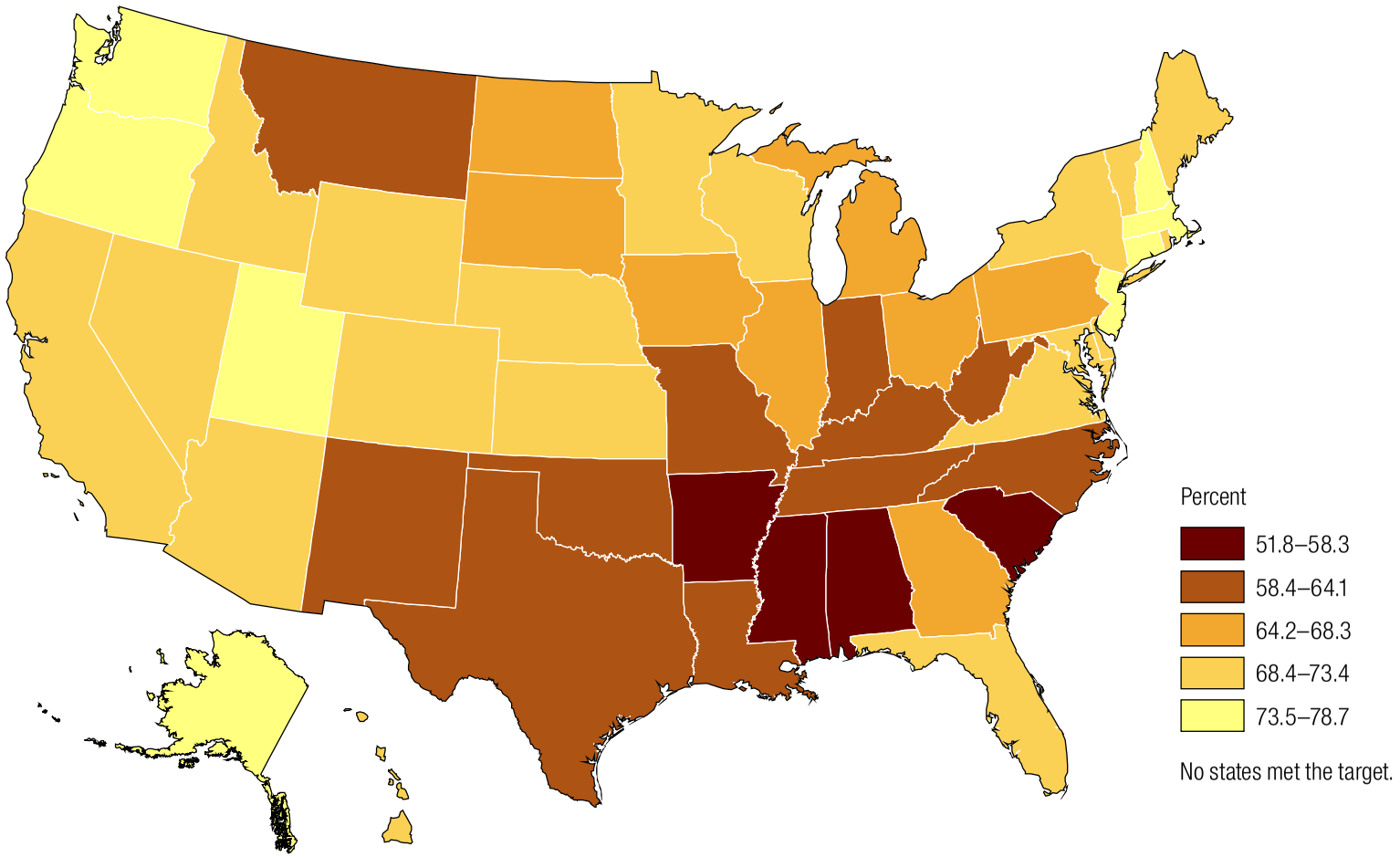
DATA SOURCES

11-1. Internet Use Supplement to the Current Population Survey (CPS): Department of Commerce, Census Bureau; Department of Labor (DOL), Bureau of Labor Statistics (BLS).

11-2a–b. National Assessment of Health Literacy (NAAL), Department of Education, National Center for Education Statistics (NCES).

11-6a–d. Medical Expenditure Panel Survey (MEPS), AHRQ.

Figure 11-3. Persons With Internet Access at Home (Age 18+), 2009
Healthy People 2010 objective 11-1 • Target = 80 percent



NOTE: Rates are displayed by a Jenks classification for U.S. states.

SOURCE: Internet Use Supplement to the Current Population Survey (CPS): Department of Commerce, Census Bureau; Department of Labor (DOL), Bureau of Labor Statistics (BLS).