

**Midcourse
Review**



Health Communication **11**

Lead Agency:

Office of Disease Prevention and Health Promotion

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Goal: Use communication strategically to improve health.

Introduction*

The six objectives in this focus area reflect multiple dimensions of strategic communication to foster and improve health. They are cross-cutting and intersect with virtually all other Healthy People 2010 objectives. Any objective that addresses communicating with or educating the public or professionals, changing behavior, building and using the information infrastructure, or encouraging health professionals to counsel or educate consumers and patients is related to the Health Communication objectives. The objectives cover diverse topics, including the diffusion of the Internet to households, health literacy improvement, research and evaluation of communication programs, quality of Internet health information sources, Centers of Excellence in Health Communication, and provider-patient communication.

The objective for households with access to the Internet moved toward its target. Satisfaction with health care providers' communication skills moved away. Followup data were not available for the Centers of Excellence objective. Data for assessing three objectives are anticipated by the end of the decade: health literacy, research and evaluation of communication programs, and quality of Internet health information sources.

Modifications to Objectives and Subobjectives

The following discussion highlights the modifications, including changes, additions, and deletions, to this focus area's objectives and subobjectives as a result of the midcourse review.

Satisfaction with health care providers' communication skills (11-6) became measurable. This objective was also modified to include four subobjectives to better capture the multiple dimensions of the provider-patient interaction.

Progress Toward Healthy People 2010 Targets

The following discussion highlights objectives that met or exceeded their 2010 targets; moved toward the targets, demonstrated no change, or moved away from the targets; and those that lacked data to assess progress. Progress is illustrated in the Progress Quotient bar chart (see Figure 11-1), which displays the percent of targeted change achieved for objectives and subobjectives with sufficient data to assess progress.

Data to assess progress toward the targets were available for two objectives. The objective for households with Internet access (11-1) moved toward its target. For satisfaction with health care providers' communication skills (11-6), all four of its subobjectives moved away from their targets. The remaining four objectives could not be assessed at the time of the midcourse review.

* Unless otherwise noted, data referenced in this focus area come from Healthy People 2010 and can be located at <http://wonder.cdc.gov/data2010>. See the section on DATA2010 in the Technical Appendix for more information.

Objectives that met or exceeded their targets. No objective for this focus area met or exceeded its target.

Objectives that moved toward their targets. The objective for households with Internet access (11-1) illustrates the uneven diffusion of Internet technology in society, known as the “digital divide.” More than 50 percent of the desired progress was achieved for this objective by the midcourse review. Between 1998 and 2003, the proportion of American households with Internet access increased from 26 percent to 55 percent, moving toward the target of 80 percent. Internet access is critical to disease prevention, health promotion, and health care because of the increasing amount of information and services available via the Internet. When Internet access is not universal, some segments of the population are excluded from knowing about and therefore using many new tools and information sources; the result is additional disparities.¹

Numerous organizations have been working to increase Internet access in households, including Federal, State, and local government agencies; foundations; nonprofit organizations; community-based organizations; schools; and technology companies.² Some of these organizations are focused not only on increasing Internet connections but also on providing meaningful access. Meaningful access encompasses all the factors that make an Internet connection valuable, such as basic computer literacy, technical support, and relevant content.

The diffusion of Internet access in households is influenced by multiple factors, many of which are not health related. First, rapid changes in technology continually raise the standards for the minimum level of service, for example, computers with faster processors or broadband instead of dial-up Internet access.¹ Some individuals are uncomfortable with computer technologies and express limited interest in the Internet as a channel of information. Certain segments of the population may have difficulty obtaining access to computer skills training on up-to-date equipment. The costs of hardware, software, and Internet connections can also be barriers to access for some populations. Further progress will require closer attention to overcoming the challenges mentioned above.²

Objectives that moved away from their targets. Patient satisfaction with health care providers’ communication skills (11-6) was tracked through four subobjectives: patients’ perception of their health care providers’ skills in listening to them (11-6a), providing understandable explanations (11-6b), showing respect for them (11-6c), and spending enough time with them (11-6d). For each of these four subobjectives, the proportion of patients who rated their health providers positively moved away from the target by 1 to 2 percentage points between 2000 and 2001. Because these small declines occurred during a 1-year period, they may not be indicative of a trend.

Increased attention has been focused on providers’ communication skills since the beginning of the decade. Professional societies promote clear communication between providers and patients.^{3,4} The National Board of Medical Examiners has instituted a clinical skills exam that assesses doctors’ communication skills as part of the U.S. Medical Licensing Examination.⁵ Within the U.S. Department of Health and Human Services (HHS), the Office of Minority Health (OMH) has developed and disseminated National Standards for Culturally and Linguistically Appropriate Services that can inform initiatives to improve communication between providers and patients from racially and ethnically diverse backgrounds.⁶ Some States, such as California⁷ and Maryland,⁸ are considering or have passed legislation directing health professional schools to provide training in cultural competency and/or health literacy

skills. New Jersey now requires physicians to take cultural competency training as a condition of licensure.⁹ These efforts, in addition to efforts by many of the same organizations mentioned above to raise awareness about health literacy issues, may produce progress toward the targets by the next data-collection point.

Objectives that could not be assessed. Progress could not be evaluated for health literacy (11-2), research and evaluation of communication programs (11-3), quality of Internet health information sources (11-4), and Centers of Excellence in Health Communication (11-5). For health literacy improvement (11-2), HHS has a partnership with the U.S. Department of Education to collect applicable health literacy data as part of the 2003 National Assessment of Adult Literacy. The objective on Centers of Excellence in Health Communication (11-5) became measurable in early 2004, and the baseline reflects the four Centers of Excellence in Cancer Communication Research supported by the National Cancer Institute within HHS. An additional data measure is anticipated by the end of the decade, using the expert opinion method, to allow progress to be assessed.

Baseline data and targets for the objectives to increase research and evaluation of health communication activities (11-3) and increase the disclosure of information to assess health websites (11-4) are anticipated by the end of the decade. One additional measurement is planned for these objectives by the end of the decade in order to assess progress.

Progress Toward Elimination of Health Disparities

The following discussion highlights progress toward the elimination of health disparities. The disparities are illustrated in the Disparities Table (see Figure 11-2), which displays information about disparities among select populations for which data were available for assessment.

Among select racial and ethnic populations, the non-Hispanic Asian or Pacific Islander group had the best rate for Internet access (11-1). The black non-Hispanic population had the best rate for all four subobjectives for satisfaction with providers' communication skills (11-6).

Compared with females, males had the better rate for Internet access (11-1). Males had better rates for reporting that providers always listen to them (11-6a), show respect (11-6c), and spend enough time with them (11-6d). Females had the better rate for reporting that providers always explain things in a way they can understand (11-6b).

Among education groups, persons with at least some college had the best rate for Internet access (11-1) and for reporting that providers explain things in a way they can understand (11-6b). For providers' listening, showing respect, and spending enough time (11-6a, c, and d), the best rate was among persons with less than a high school education. Persons living in urban or metropolitan areas had better Internet access than residents in rural or nonmetropolitan areas. The latter, however, had the better rate for all four subobjectives for providers' communication skills. Persons with disabilities had the better rate for providers' listening carefully. Persons without disabilities had the better rate on the other three dimensions for providers' communication skills (11-6b, c, and d). No statistically significant disparities or disparities of 10 percent or more were noted for gender, urban-rural location, or disability status.

Less than half as many households in the Hispanic and black non-Hispanic populations had Internet access (11-1) as did households in the non-Hispanic Asian or Pacific Islander (best) population. Between 1998 and 2001, the disparity between these two populations and the best group increased by 50 percent to 99 percentage points. A smaller increase in disparity (10 percent to 49 percentage points) was seen between the white non-Hispanic population and the best group. Disparities also increased among households headed by persons with a high school education or less, compared with persons with at least some college. Despite these increases in disparity, all racial and ethnic populations and populations by level of education moved toward the target. For example, between 1998 and 2001, the percent of Hispanic and black non-Hispanic households with Internet access more than doubled. Internet access in households of high school graduates also doubled.

The non-Hispanic Asian or Pacific Islander group had the largest disparities from the black non-Hispanic (best) population for patients reporting that health providers always listen, provide understandable explanations, and show respect (11-6a, b, and c). The white non-Hispanic population had an increase in disparity for persons reporting that their providers always listen carefully to them (11-6a) and have respect for what they say (11-6c). The Hispanic group experienced a decrease in disparities of 10 to 49 percentage points from the best group in reporting that their providers explain topics in a way they understand (11-6b). High school graduates experienced a 10 to 49 percentage point increase in disparity, compared with persons with less than a high school education, regarding providers always showing respect for them (11-6c).

More research is needed to identify the most important factors affecting patient-provider communication and the ways these factors interact with each other. Even without additional research, patients representing select racial and ethnic populations may experience a change in their providers' behavior as a result of initiatives in cultural competency. Multiple organizations, including OMH and the Health Resources and Services Administration within HHS, as well as the Nation's medical schools, are working to provide standards and training in cultural competency skills. Cultural competency training is designed to enhance providers' ability to listen effectively, show respect, and provide information to patients in appropriate ways. The dissemination of cultural competency training for health care students and practitioners already in the community is one promising approach that could help decrease disparities.^{10, 11}

Opportunities and Challenges

Communicating Health: Priorities and Strategies for Progress describes action plans for each of the six health communication objectives.² Health communication, however, involves all disease prevention and health promotion topics, every sector of the population, and rapidly changing technology and information. The challenges to making progress are numerous.

Internet access (11-1) is rapidly migrating from dial-up to broadband Internet service because of the greater range of functionality and download speeds.¹ Many online applications are not accessible or do not work well over dial-up connections.¹ Home-based access to computers and the Internet may be less important for some populations that choose other technologies such as cell phones to communicate and access content.¹² The objective will need to be considered in light of these technical changes to ensure that the data capture not only where but how people use technologies to access health information.

The release of two reports on health literacy has generated additional interest in health literacy improvement (11-2).^{13,14} Several new initiatives address the issues raised in these reports. The Institute of Medicine (IOM) has secured sponsors for a roundtable to convene stakeholders in health literacy improvement.¹⁵ The roundtable will identify ways to move forward the agenda from the IOM report.¹³

The National Quality Forum and the Joint Commission on Accreditation of Healthcare Organizations have both initiated projects on patient safety and health literacy improvement.^{16,17} Recognizing the need to strengthen the health literacy literature, the National Institutes of Health and the Agency for Healthcare Research and Quality (AHRQ) have sponsored a program announcement to foster more research.¹⁸

One of the main barriers to action is a lack of awareness about health literacy issues among policymakers and organizational leadership.² Even when awareness exists, more than the commitment of senior management is necessary to create changes in organizational and professional practices that would reduce health literacy barriers. These sectors include, but are not limited to, Federal and State government agencies, health care facilities, health care professional societies, insurers, and the mass media.² Opportunities exist to train health care providers, develop professional curricula, influence clinical policy development, and partner with health care professional societies to address health literacy.

Increasing research and evaluation of health communication activities (11-3) is a challenge.² The action plan for the objective identifies the following main factors affecting the amount of health communication research and evaluation.² In the Federal context, programs must secure clearance to conduct research and evaluation. In general, expectations of what communication research can accomplish can be unrealistic, and distinguishing the contribution of communication to the project outcomes can be difficult. Programs may not use appropriate research models or have personnel with training who can conduct communication research and evaluation. Finally, when resources are scarce, producing messages and materials may be prioritized over conducting research and evaluation.

The action plan for the disclosure of elements to assess health websites (11-4) is intended to provide a foundation for future efforts to assess quality more directly.² In the absence of consensus in the field about quality metrics and assessment tools, the measurement of the objective will proceed with the six criteria in the *Healthy People 2010* publication. The criteria are the presence or absence of the following: the identity of website sponsors or developers, the purpose of the site, content development practices, privacy policies, evaluation and feedback mechanisms, and content updates. The quality of health information on the Internet will remain a high-priority issue as the Internet becomes an increasingly common information channel.¹⁹

Several strategies have been proposed to increase the number of Centers of Excellence in Health Communication (11-5), and these strategies are summarized in the action plan for the objective.² Through two of its agencies, HHS has supported three new centers since 2004: AHRQ—Clinical Decisions and Communications Science Center, Oregon Health & Science University,²⁰ and the Centers for Disease Control and Prevention—Southern Center on Communication, Health and Poverty, University of Georgia, and the Center of Excellence for Health Communication and Marketing, University of Connecticut.²¹ The Indian Health Service within HHS is considering how to support future centers. The opportunities lie in stakeholder collaboration to create and promote other centers by systematizing data collection and reporting on center operations, developing infrastructure—human and physical—to support center operations, publishing articles on center activities, training more health communication professionals, and recognizing publicly the contributions that centers make to the field.²

The objective on patients' satisfaction with health care providers' communication skills (11-6) would benefit from more precise metrics and a focus on the training and licensing of all types of health care providers.² Many current initiatives focus primarily or exclusively on physicians, who are only one type of provider. Some of the steps in the objective's action plan include expanding assessments of other types of providers, including nurses, dentists, hygienists, pharmacists, and therapists; developing closer connections between cultural competence and clinical communication initiatives; and focusing assessment efforts on the quality of patient-provider interactions.²

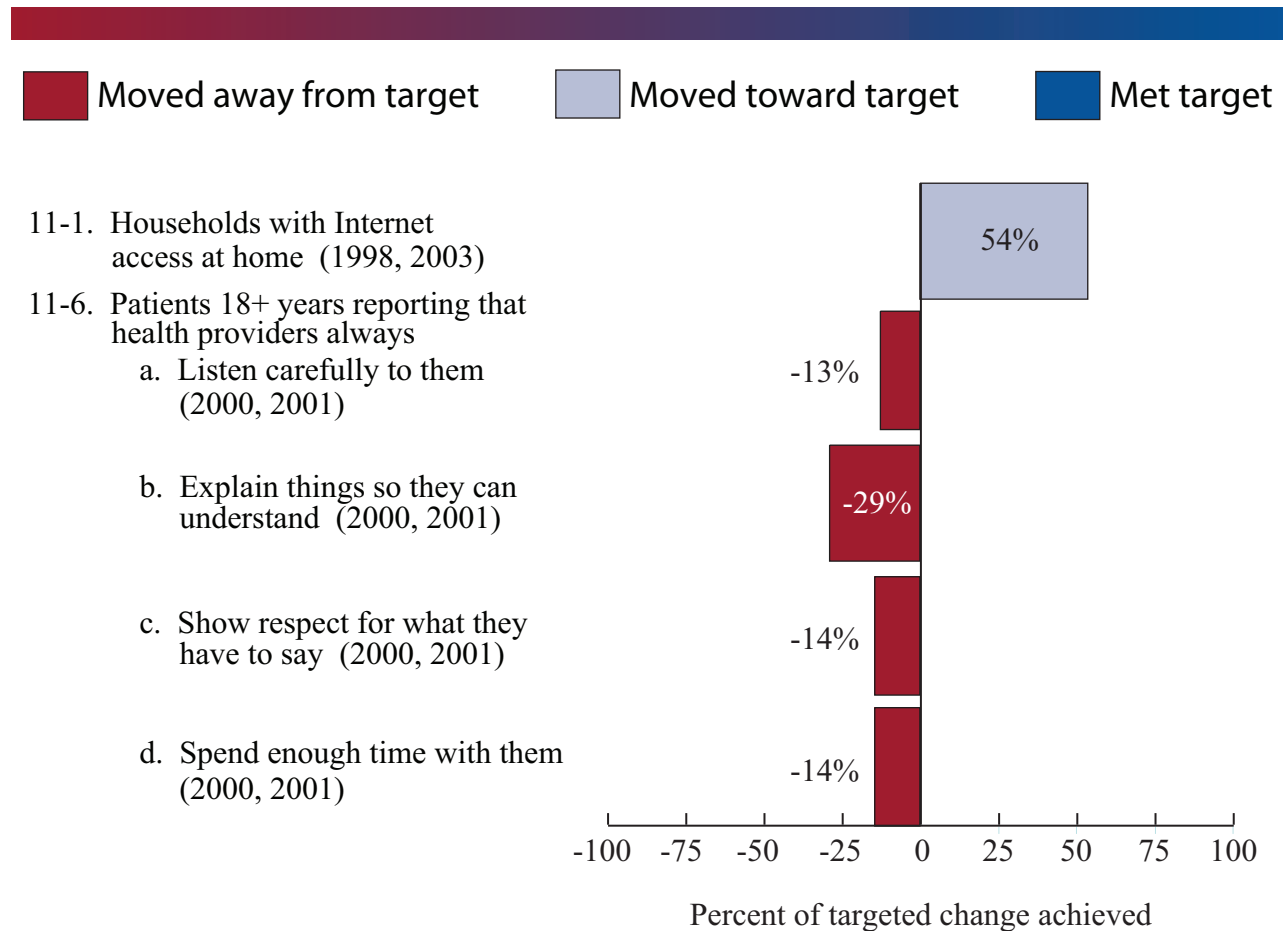
Emerging Issues

The communication landscape continues to change rapidly in response to the emergence of new technologies and new ways of creating and exchanging information. The health policy landscape is also changing to include an emphasis on health information technology and consumer empowerment through technology.²² In conjunction with electronic health records owned by health care facilities, personal health record systems are being proposed as a means to provide consumers with control of their own health information and to facilitate information exchange with providers and organizations.^{22, 23, 24} Although personal health records have not been widely diffused, evidence about "disruptive technologies," such as instant messaging, blogging, and podcasting, indicates consumers are willing to adopt new technologies if they fit users' purposes.¹

In addition to the Internet, marketing is a major source of health information for the public. IOM's recent study on food and beverage marketing to children and the Kaiser Family Foundation's study of direct-to-consumer advertising of prescription drugs indicate that this type of information can be influential in health decisions.^{25, 26} Helping the public locate and assess health information is an ongoing issue.

Emerging public health threats, such as avian influenza, natural disasters, and bioterrorist events, present major challenges to health communication planning and implementation.^{27, 28} The examples of Hurricanes Katrina and Rita indicate that communication must occur among first responders and the public even when the infrastructure has been destroyed.²⁷ First responders must be able to communicate among themselves and with the public. The public must have reliable access to trusted sources and reliable information to prepare and respond to emergencies.²⁷ Anticipating the communication requirements of first responders and the public as public health threats emerge has been identified as a national priority.^{27, 28}

Figure 11-1. Progress Quotient Chart for Focus Area 11: Health Communication



Notes: Tracking data for objectives 11-2 through 11-5 are unavailable.

Years in parentheses represent the baseline data year and the most recent data year used to compute the percent of the Healthy People 2010 target achieved.

$$\text{Percent of targeted change achieved} = \left(\frac{\text{Most recent value} - \text{baseline value}}{\text{Year 2010 target} - \text{baseline value}} \right) \times 100$$

Figure 11-2. 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.

Population-based objectives		Characteristics																
		Race and ethnicity								Gender		Education			Location		Disability	
		American Indian or Alaska Native	Asian	Native Hawaiian or other Pacific Islander	Two or more races	Hispanic or Latino	Black non-Hispanic	White non-Hispanic	Summary index	Female	Male	Less than high school	High school graduate	At least some college	Summary index	Urban or metropolitan	Rural or nonmetropolitan	Persons with disabilities
11-1.	Households with Internet access (1998, 2001) ^{† 1}		B ²			↑↑	↑↑	↑	↑↑		B	↑	↑	B	↑	B		
11-6a.	Patients reporting that health providers always listen carefully to them: 18+ years (2000, 2001) *	3	2				B	↑			B	B				B	B	
11-6b.	Patients reporting that health providers always explain things so they can understand: 18+ years (2000, 2001) *	3	2			↓	B			B			B			B		B
11-6c.	Patients reporting that health providers always show respect for what they have to say: 18+ years (2000, 2001) *	3	2				B	↑			B	↑		↑		B		B
11-6d.	Patients reporting that health providers always spend enough time with them: 18+ years (2000, 2001) *	3	2				B				B					B		B

Notes: Data for objectives 11-2 through 11-5 are unavailable or not applicable.

Years in parentheses represent the baseline data year and the most recent data year (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 (for example, 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.

The best group rate at the most recent data point.		The group with the best rate for specified characteristic.		Most favorable group rate for specified characteristic, but reliability criterion not met.		Best group rate reliability criterion not met.		
Percent difference from the best group rate								
Disparity from the best group rate at the most recent data point.		Less than 10 percent or not statistically significant		10-49 percent		50-99 percent		100 percent or more
	Increase in disparity (percentage points)							
Changes in disparity over time are shown when 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.	↑	10-49	↑↑	50-99	↑↑↑	100 or more		
	Decrease in disparity (percentage points)							
	↓	10-49	↓↓	50-99	↓↓↓	100 or more		
Availability of data.		Data not available.		Characteristic not selected for this objective.				

* The variability of best group rates was assessed, and disparities of ≥ 10% are statistically significant at the 0.05 level. Changes in disparity over time, noted with arrows, are statistically significant at the 0.05 level. See Technical Appendix.

[†] Measures of variability were not available. Thus, the variability of best group rates was not assessed, and the statistical significance of disparities and changes in disparity over time could not be tested. See Technical Appendix.

¹ Although the most recent data year for the overall objective is 2003, the most recent data by population characteristics are for 2001.

² Data are for non-Hispanic Asians or Pacific Islanders.

³ Data are for non-Hispanic American Indians or Alaska Natives.

Objectives and Subobjectives for Focus Area 11: Health Communication

Goal: Use communication strategically to improve health.

As a result of the Healthy People 2010 Midcourse Review, changes were made to the Healthy People 2010 objectives and subobjectives. These changes are specific to the following situations:

- Changes in the wording of an objective to more accurately describe what is being measured.
- Changes to reflect a different data source or new science.
- Changes resulting from the establishment of a baseline and a target (that is, when a formerly developmental objective or subobjective became measurable).
- Deletion of an objective or subobjective that lacked a data source.
- Correction of errors and omissions in *Healthy People 2010*.

Revised baselines and targets for measurable objectives and subobjectives do not fall into any of the above categories and, thus, are not considered a midcourse review change.¹

When changes were made to an objective, three sections are displayed:

1. In the Original Objective section, the objective as published in *Healthy People 2010* in 2000 is shown.
2. In the Objective With Revisions section, strikethrough indicates text deleted, and underlining is used to show new text.
3. In the Revised Objective section, the objective appears as revised as a result of the midcourse review.

Details of the objectives and subobjectives in this focus area, including any changes made at the midcourse, appear on the following pages.

¹ See Technical Appendix for more information on baseline and target revisions.

NO CHANGE IN OBJECTIVE

11-1. Increase the proportion of households with access to the Internet at home.

Target: 80 percent.

Baseline: 26 percent of households had access to the Internet at home in 1998.

Target setting method: Better than the best.

Data source: Computer and Internet Use Supplement to the Current Population Survey, U.S. Department of Commerce, Bureau of the Census.

NO CHANGE IN OBJECTIVE

11-2. (Developmental) Improve the health literacy of persons with inadequate or marginal literacy skills.

Potential data source: National Adult Literacy Survey, 2002, U.S. Department of Education.

NO CHANGE IN OBJECTIVE

11-3. (Developmental) Increase the proportion of health communication activities that include research and evaluation.

Potential data sources: Sponsored survey of *Federal Register* notices; Grantmakers in Health; National Health Council.

NO CHANGE IN OBJECTIVE

11-4. (Developmental) Increase the proportion of health-related World Wide Web sites that disclose information that can be used to assess the quality of the site.

Potential data sources: Health on the Net Foundation; Health Internet Ethics (Hi-Ethics); Internet Healthcare Coalition.

ORIGINAL OBJECTIVE

11-5. (Developmental) Increase the number of Centers of Excellence that seek to advance the research and practice of health communication.

Potential data sources: Health Communication Interest Group, American Public Health Association; Society for Social Marketing; Association of Schools of Public Health; Health Communication Divisions, International Communication Association and National Communication Association; NCI.

OBJECTIVE WITH REVISIONS

11-5. (Developmental) Increase the number of Centers of Excellence that seek to advance the research and practice of health communication.

Target: 6 Centers of Excellence for Health Communication.

Baseline: 4 Centers of Excellence for Health Communication existed in 2003.

Target setting method: Expert opinion.

Potential dData sources: ~~Health Communication Interest Group, American Public Health Association; Society for Social Marketing; Association of Schools of Public Health; Health Communication Divisions, International Communication Association and National Communication Association; NIH, NCI.~~

REVISED OBJECTIVE

11-5. Increase the number of Centers of Excellence that seek to advance the research and practice of health communication.

Target: 6 Centers of Excellence for Health Communication.

Baseline: 4 Centers of Excellence for Health Communication existed in 2003.

Target setting method: Expert opinion.

Data source: NIH, NCI.

ORIGINAL OBJECTIVE

11-6. (Developmental) Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

Potential data sources: National Committee for Quality Assurance; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP; National Health Interview Survey (NHIS), CDC, NCHS; industry surveys (FIND/SVP, Nielsen, Jupiter Communications).

OBJECTIVE WITH REVISIONS

11-6. (Developmental) Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

Target and baseline:

Objective	Increase in Patients Reporting That Doctors or Other Health Providers Always	2000 Baseline	2010 Target
		<i>Percent</i>	
11-6a.	Listen carefully to them	56	64
11-6b.	Explain things so they can understand	58	65
11-6c.	Show respect for what they have to say	58	65
11-6d.	Spend enough time with them	45	52

Target setting method: Better than the best.

Potential data sources: National Committee for Quality Assurance; Behavioral Risk Factor Surveillance System (BRFSS), CDC, NCCDPHP; National Health Interview Survey (NHIS), CDC, NCHS; industry surveys (FIND/SVP, Nielsen, Jupiter Communications) Medical Expenditure Survey (MEPS), AHRQ.

REVISED OBJECTIVE

11-6. Increase the proportion of persons who report that their health care providers have satisfactory communication skills.

Target and baseline:

Objective	Increase in Patients Reporting That Doctors or Other Health Providers Always	2000 Baseline	2010 Target
		<i>Percent</i>	
11-6a.	Listen carefully to them	56	64
11-6b.	Explain things so they can understand	58	65
11-6c.	Show respect for what they have to say	58	65
11-6d.	Spend enough time with them	45	52

REVISED OBJECTIVE *(continued)*

Target setting method: Better than the best.

Data source: Medical Expenditure Survey (MEPS), AHRQ.

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Related Objectives From Other Focus Areas

1. Access

- 1-3. Counseling about health behaviors
- 1-12. Single toll-free number for poison control centers

2. Arthritis, Osteoporosis, and Chronic Back Conditions

- 2-8. Arthritis education

3. Cancer

- 3-10. Provider counseling about cancer prevention

4. Chronic Kidney Disease

- 4-3. Counseling for chronic kidney failure care

5. Diabetes

- 5-1. Diabetes education

7. Educational and Community-Based Programs

- 7-2. School health education
- 7-3. Health-risk behavior information for college and university students
- 7-5. Worksite health promotion programs
- 7-10. Community health promotion programs
- 7-11. Culturally appropriate and linguistically competent community health promotion programs

9. Family Planning

- 9-11. Reproductive health education

10. Food Safety

- 10-5. Consumer food safety practices

12. Heart Disease and Stroke

- 12-2. Knowledge of symptoms of heart attack and importance of dialing 911
- 12-4. Cardiopulmonary resuscitation (CPR) training
- 12-8. Knowledge of early warning symptoms of stroke

13. HIV

- 13-8. HIV counseling and education for persons in substance abuse treatment

16. Maternal, Infant, and Child Health

- 16-7. Childbirth classes
- 16-13. Infants put to sleep on their backs

17. Medical Product Safety

- 17-4. Receipt of useful information about prescriptions from pharmacies
- 17-5. Receipt of oral counseling about medications from prescribers and dispensers
- 17-6. Blood donations

19. Nutrition and Overweight

- 19-16. Worksite promotion of nutrition education and weight management
- 19-17. Nutrition counseling for medical conditions

23. Public Health Infrastructure

- 23-2. Public access to information and surveillance data

24. Respiratory Diseases

- 24-6. Patient education

25. Sexually Transmitted Diseases

- 25-12. Responsible sexual behavior messages on television

26. Substance Abuse

- 26-17. Perception of risk associated with substance abuse

27. Tobacco Use

- 27-16. Tobacco advertising and promotion targeting adolescents and young adults