



HHS Public Access

Author manuscript

Health Aff Sch. Author manuscript; available in PMC 2023 December 15.

Published in final edited form as:

Health Aff Sch. 2023 October ; 1(4): . doi:10.1093/haschl/qxad050.

Social media users' perceptions about health mis- and disinformation on social media

Jim P. Stimpson^{1,*}, Alexander N. Ortega²

¹Peter O'Donnell Jr. School of Public Health, University of Texas Southwestern Medical Center, Dallas, TX 75390, United States

²Thompson School of Social Work and Public Health, University of Hawai'i at Mānoa, Honolulu, HI 96822, United States

Abstract

This study used recently released nationally representative data with new measures on health information seeking to estimate the prevalence and predictors of adult social media users' perceptions of health mis- and disinformation on social media. Most adults who use social media perceive some (46%) or a lot (36%) of false or misleading health information on social media, but nearly one-fifth reported either none or a little (18%). More than two-thirds of participants reported that they were unable to assess social media information as true or false (67%). Our study identified certain population groups that might be a focus of future intervention work, such as participants who use social media to make decisions. The perception by social media users that false and misleading health information on social media is highly prevalent may lend greater urgency to mitigate the spread of false or misleading health information that harms public health.

Keywords

United States; cross-sectional study; consumer health information; misinformation; disinformation

Introduction

False or misleading information has become a major social and public health problem because research has shown that it can spread faster and more broadly than accurate information, and it can cause confusion and mistrust of institutions charged with protecting the public's health.¹⁻⁵ Misinformation is false or inaccurate information, while disinformation is intentionally disseminating false or inaccurate information.⁶ Mis- and

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial License (<https://creativecommons.org/licenses/by-nc/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com

*Corresponding author: Peter O'Donnell Jr. School of Public Health, University of Texas Southwestern Medical Center, 5323 Harry Hines Blvd, Dallas, TX 75390, United States. james.stimpson@utsouthwestern.edu.

Supplementary material

Supplementary material is available at *Health Affairs Scholar* online.

Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

disinformation on social media have influenced the adoption of harmful behaviors and reduced health-promoting behaviors.⁷⁻⁹ Yet, physicians and scientists attempting to counter mis- and disinformation have been subjected to online harassment.¹⁰ Congressional Republicans have recently taken aim at universities and Think Tanks researching disinformation through records requests, subpoenas, and lawsuits.¹¹ Despite these attempts to chill research into disinformation, we need more evidence to counter the growing prevalence of health mis- and disinformation.

Recent studies of health mis- and disinformation have been motivated by anti-vaccine campaigns¹²⁻¹⁸ and the impact of mis- and disinformation on health behaviors such as smoking and nutrition.¹⁹⁻²² The recent studies on health mis- and disinformation have consisted of innovative and well-designed machine-learning analyses of social media content to extract and classify false information being spread through news sources and social media influencers about the COVID-19 pandemic.²³⁻²⁹ These studies have provided insight into the prevalence of false information on social media, ranging up to 87% of posts, depending on the specific topic.³

Given the recency of the problem of false and misleading social media information and limited nationally representative survey data from social media users, there is a need to better understand social media users' perception of mis- and disinformation on social media because there is recent evidence that this perception may be a mechanism for harmful beliefs and behaviors.³⁰ To be prepared for the growing prevalence of mis- and disinformation regarding critical health issues, the public health community needs more information about the perceptions of health misinformation on social media among specific populations of social media users.^{30,31} Therefore, the objective of this study was to use recently released nationally representative data with new measures on health information seeking to estimate the prevalence and predictors of perceptions of false or misleading health information among adult social media users.

Data and methods

Data

This study used cross-sectional survey data from the Health Information National Trends Survey 6 (HINTS 6), which is a nationally representative sample of noninstitutionalized adults 18 years of age and older in the United States sponsored by the National Cancer Institute.³² HINTS 6 data were collected as a mail and online survey from March to November 2022, with a response rate of 28.1%. Participants who had not visited a social media site in the past year or reported that they do not use social media were excluded. After using listwise deletion for cases with missing data, the analytical sample consisted of 3841 adult respondents. HINTS 6 is publicly available with de-identified data; therefore, the university human research protection program deemed it exempt from institutional review board approval. Further details about the survey can be found in methodology reports produced by the National Cancer Institute.³²

Measures

The first outcome was assessed by the following question: “How much of the health information that you see on social media do you think is false or misleading?” The response categories were as follows: I do not use social media, none, a little, some, a lot. We dichotomized this measure as none/a little vs some/a lot. Those reporting that they do not use social media were coded as missing. The second outcome asked participants, “I find it hard to tell whether health information on social media is true or false.” The response categories were strongly agree, somewhat agree, somewhat disagree, and strongly disagree, and the responses were recoded as agree or disagree.

Demographic predictors included age (18–49, 50–64, 65+ years), sex (male, female), marital status (married/cohabiting, formerly married, never married), residence in a metro/nonmetropolitan county as designated by the US Department of Agriculture in 2013, race/ethnicity (non-Latino White, non-Latino Black, Latino, non-Latino Asian American/Other), education (high school or less, some college, college degree or higher), full-time employment status, and feelings about household income (finding it very/difficult on present income, getting by on present income, living comfortably on present income).

Predictors of social media use included frequency of visiting social media sites (monthly, weekly, daily) and in the past 12 months ever sharing personal health information, sharing general health-related information, interacting with people who have similar health or medical issues, and watching a health-related video. Other predictors of social media use were asked with a Likert scale and converted to dichotomous measures (agree or disagree): “Most of the people in my social media networks have the same views about health as me,” “I use information from social media in discussions with my health care provider,” and “I use information from social media to make decisions about my health.”

Statistical analysis

All analyses account for survey weights and design using jackknife replicate weights for variance estimation. Statistical significance was defined as a P value $< .05$. Predictors of perceptions of false or misleading social media information were calculated with multivariable linear probability models and reported as predicted probabilities and 95% confidence intervals. Predictors of perceptions of whether the participant could assess social media information as true or false were calculated with multivariable linear probability models and reported as predicted probabilities and 95% confidence intervals. The supplemental appendix includes the survey-weighted bivariate analyses of the outcomes and predictors in Table A1 and an ordered logit regression for an alternative measurement of perceptions of false or misleading social media information (none/a little, some, a lot) in Table A2.

Results

Table 1 shows the survey-weighted descriptive statistics for the study sample. Most of the sample consisted of individuals aged 18–49 years (60%), female (53%), married or cohabiting (58%), residing in metropolitan areas (88%), identifying their race/ethnicity as

non-Latino White (61%), educated beyond high school degree (76%), working full time (61%), and not finding it very difficult on their present income (81%). Most participants visited social media sites daily (74%), did not share personal (81%) or general health information (62%) on social media, did not interact with people with similar health or medical issues on social media (73%), and reported watching a health-related video (70%). Most participants disagreed that most people in social media have the same views about health as the participant (54%) and disagreed that they use social media information in discussion with their health care providers (80%) or to make decisions about their health (84%). The most prevalent perception of the prevalence of false or misleading social media information is some (46%) followed by a lot (36%) and none/a little (18%). More than two-thirds of the sample reported that they were unable to assess social media information as true or false (67%). The most prevalent opinion about who is most responsible for reducing false or misleading social media information was social media companies (33%) followed by individual users/other (25%) and government (15%), medical providers/health care systems (14%), and news media (13%).

Table 2 shows the predictors for public perceptions about the prevalence of false or misleading social media information from linear probability models. Latinos (probability = -0.10 ; 95% CI, -0.17 to -0.04) and non-Latino Black individuals (probability = -0.11 ; 95% CI, -0.18 to -0.05) were less likely to report a high prevalence of false or misleading social media information compared with non-Latino White individuals. Participants who used social media to make health decisions (probability = -0.10 ; 95% CI, -0.18 to -0.02) were also less likely to report a high prevalence of false or misleading social media information compared with participants who did not use social media to make health decisions.

Table 2 also shows the predictors of whether the participant agrees that they cannot assess social media information as true or false from linear probability models. Participants 65 years and older (probability = 0.11 ; 95% CI, 0.03 – 0.20), participants who agreed that most people in social media have the same views about health as the participant (probability = 0.10 ; 95% CI, 0.05 – 0.14), and participants who use social media to make health decisions (probability = 0.09 ; 95% CI, 0.01 – 0.17) were more likely to report being unable to assess social media information as true or false compared with their reference categories. Latino participants were less likely to report being unable to assess social media information as true or false (probability = -0.09 ; 95% CI, -0.16 to -0.02) compared with non-Latino White participants.

Discussion

This study found that most adult social media users in the United States reported a high prevalence of false or misleading health information on social media. Our finding that 82% of adult social media users perceived false or misleading health information on social media is consistent with estimates from objective content analyses of social media posts that ranged up to 87%, which suggests that the public is accurately perceiving a high prevalence of health misinformation. However, most social media users also reported that they were unable to assess health information on social media as true or false, which indicates that an area of future inquiry is to better understand why social media users perceive a high

prevalence of health misinformation yet claim to be unable to assess the accuracy of health information.³³

There were several demographic characteristics that were consistently a predictor for perceptions of misinformation that warrant further consideration in future studies, including age, race/ethnicity, and education. We found that Latinos and non-Latino Black individuals were less likely to report a high prevalence of false or misleading social media information compared with non-Latino White individuals. Moreover, Latinos were less likely to report being unable to assess social media information as true or false. There is growing evidence that historically disadvantaged race or ethnic populations are more likely to receive, consume, and share fake news and mis- and disinformation online compared with the general population.^{34,35} Possibly, the higher level of engagement in false or misleading information online due to access barriers to accurate information from government sources or medical professionals may shape perceptions of the prevalence of false or misleading social media information. Therefore, supporting the health information needs of historically disadvantaged racial or ethnic persons may require improving access to health care and official government information that is available to persons who experience language or health literacy barriers.³⁶

The findings should be interpreted within the limitations of using cross-sectional survey data. It is important to note that this study represents the first instance in which the public's perceptions of misinformation were included in the HINTS 6 survey; thus, the analyses were restricted to a single cross-section. If this measure is collected in subsequent iterations of HINTS, then trend analyses to detect changes over time may provide additional insights into the prevalence and predictors of false and misleading information.

Conclusion

Our study identified specific social media users that might be a focus of future intervention work, such as participants who use social media to make decisions or who agreed that most people in social media have the same views about health as them. The perception by adult social media users that false and misleading health information on social media is highly prevalent may lend even greater urgency to mitigate the spread of false or misleading health information that harms public health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Funding

This research was supported by the National Institute on Minority Health and Health Disparities (NIMHD) under award number R01MD018727. The content is solely the responsibility of the authors and does not necessarily represent the official views of NIMHD. The funders had no role in study design, data analysis, decision to publish, or preparation of the manuscript.

Notes

1. Southwell BG, Brennen JS, Paquin R, Boudewyns V, Zeng J. Defining and measuring scientific misinformation. *Ann Am Acad Political Social Sci.* 2022;700(1):98–111.
2. Nan X, Wang Y, Thier K. Why do people believe health misinformation and who is at risk? A systematic review of individual differences in susceptibility to health misinformation. *Soc Sci Med.* 2022; 314:115398. 10.1016/j.socscimed.2022.115398 [PubMed: 36327631]
3. Suarez-Lledo V, Alvarez-Galvez J. Prevalence of health misinformation on social media: systematic review. *J Med Internet Res.* 2021;23(1):e17187. 10.2196/17187 [PubMed: 33470931]
4. Yang K-C, Pierri F, Hui PM, et al. The COVID-19 infodemic: Twitter versus Facebook. *Big Data Soc.* 2021;8(1): 20539517211013861.
5. Park S, Massey PM, Stimpson JP. Primary source of information about COVID-19 as a determinant of perception of COVID-19 severity and vaccine uptake: source of information and COVID-19. *J Gen Intern Med.* 2021;36(10):3088–3095. 10.1007/s11606-021-07080-1 [PubMed: 34378115]
6. Aïmeur E, Amri S, Brassard G. Fake news, disinformation and misinformation in social media: a review. *Soc Netw Anal Min.* 2023;13(1):30. 10.1007/s13278-023-01028-5 [PubMed: 36789378]
7. Perlis RH, Ognyanova K, Santillana M, et al. Association of major depressive symptoms with endorsement of COVID-19 vaccine misinformation among US adults. *JAMA Netw Open.* 2022;5(1): e2145697. 10.1001/jamanetworkopen.2021.45697 [PubMed: 35061036]
8. Sylvia Chou W-Y, Gaysynsky A, Cappella JN. Where we go from here: health misinformation on social media. *Am J Public Health.* 2020;110(S3):S273–S275. 10.2105/AJPH.2020.305905 [PubMed: 33001722]
9. Walsh-Buhi ER. Social media and cancer misinformation: additional platforms to explore. *Am J Public Health.* 2020;110(S3): S292–S293. 10.2105/AJPH.2020.305949 [PubMed: 33001721]
10. Royan R, Pendergrast TR, Woitowich NC, et al. Physician and biomedical scientist harassment on social media during the COVID-19 pandemic. *JAMA Netw Open.* 2023;6(6):e2318315. 10.1001/jamanetworkopen.2023.18315 [PubMed: 37314808]
11. Bernstein A Republican Rep. Jim Jordan issues sweeping information requests to universities researching disinformation. ProPublica. March 22, 2023. Accessed September 1, 2023. <https://www.propublica.org/article/jim-jordan-disinformation-subpoena-universities>
12. Whitehead HS, French CE, Caldwell DM, Letley L, Mounier-Jack S. A systematic review of communication interventions for countering vaccine misinformation. *Vaccine.* 2023;41(5):1018–1034. 10.1016/j.vaccine.2022.12.059 [PubMed: 36628653]
13. Silver N, Kierstead E, Kostygina G, et al. The influence of provaping “gatewatchers” on the dissemination of COVID-19 misinformation on Twitter: analysis of Twitter discourse regarding nicotine and the COVID-19 pandemic. *J Med Internet Res.* 2022;24(9):e40331. 10.2196/40331 [PubMed: 36070451]
14. Kumar N, Walter N, Nyhan K, et al. Interventions to mitigate COVID-19 misinformation: protocol for a scoping review. *Syst Rev.* 2022;11(1):107. 10.1186/s13643-022-01917-4 [PubMed: 35637514]
15. Zhao S, Hu S, Zhou X, et al. The prevalence, features, influencing factors, and solutions for COVID-19 vaccine misinformation: systematic review. *JMIR Public Health Surveill.* 2023;9:e40201. 10.2196/40201 [PubMed: 36469911]
16. Janmohamed K, Walter N, Nyhan K, et al. Interventions to mitigate COVID-19 misinformation: a systematic review and meta-analysis. *J Health Commun.* 2021;26(12):846–857. 10.1080/10810730.2021.2021460 [PubMed: 35001841]
17. Kornides ML, Badlis S, Head KJ, Putt M, Cappella J, Gonzalez-Hernandez G. Exploring content of misinformation about HPV vaccine on twitter. *J Behav Med.* 2023;46(1–2):239–252. 10.1007/s10865-022-00342-1 [PubMed: 35896853]
18. Llavona-Ortiz JY, Spanos KE, Kraschnewski JL, et al. Associations between human papillomavirus vaccine decisions and exposure to vaccine information in social media. *Cancer Control.* 2022;29: 10732748221138404. 10.1177/10732748221138404

19. Janmohamed K, Walter N, Sangngam N, et al. Interventions to mitigate vaping misinformation: a meta-analysis. *J Health Commun.* 2022;27(2):84–92. 10.1080/10810730.2022.2044941 [PubMed: 35220901]
20. Morgan JC, Cappella JN. The effect of repetition on the perceived truth of tobacco-related health misinformation among U.S. adults. *J Health Commun.* 2023;28(3):182–189. 10.1080/10810730.2023.2192013 [PubMed: 36938585]
21. Nguyen V, Testa L, Smith AL, et al. Unravelling the truth: examining the evidence for health-related claims made by naturopathic influencers on social media—a retrospective analysis. *Health Promot Perspect.* 2022;12(4):372–380. 10.34172/hpp.2022.49 [PubMed: 36852198]
22. Diekman C, Ryan CD, Oliver TL. Misinformation and disinformation in food science and nutrition: impact on practice. *J Nutr.* 2023;153(1):3–9. 10.1016/j.tjnut.2022.10.001 [PubMed: 36913465]
23. Lanier HD, Diaz MI, Saleh SN, Lehmann CU, Medford RJ. Analyzing COVID-19 disinformation on Twitter using the hashtags #scamdemic and #plandemic: retrospective study. *PLoS One.* 2022;17(6): e0268409. 10.1371/journal.pone.0268409 [PubMed: 35731785]
24. Hunt K, Agarwal P, Zhuang J. Monitoring misinformation on Twitter during crisis events: a machine learning approach. *Risk Anal.* 2022;42(8):1728–1748. 10.1111/risa.13634 [PubMed: 33190276]
25. Hakak S, Alazab M, Khan S, Gadekallu TR, Maddikunta PK, Khan WZ. An ensemble machine learning approach through effective feature extraction to classify fake news. *Future Gener Comput Syst.* 2021;117:47–58.
26. Kim J, Aum J, Lee S, Jang Y, Park E, Choi D. FibVID: comprehensive fake news diffusion dataset during the COVID-19 period. *Telemat Inform.* 2021;64:101688. 10.1016/j.tele.2021.101688 [PubMed: 36567815]
27. Haupt MR, Li J, Mackey TK. Identifying and characterizing scientific authority-related misinformation discourse about hydroxychloroquine on Twitter using unsupervised machine learning. *Big Data Soc.* 2021;8(1):20539517211013843.
28. Lyu H, Zheng Z, Luo J. Misinformation versus facts: understanding the influence of news regarding COVID-19 vaccines on vaccine uptake. *Health Data Sci.* 2022;2022:9858292. 10.34133/2022/9858292
29. Lamsal R. Design and analysis of a large-scale COVID-19 tweets dataset. *Appl Intell (Dordr).* 2021;51(5):2790–2804. 10.1007/s10489-020-02029-z [PubMed: 34764561]
30. Matthes J, Corbu N, Jin S, et al. Perceived prevalence of misinformation fuels worries about COVID-19: a cross-country, multi-method investigation. *Inform, Commun Soc.* 2022:1–24. 10.1080/1369118X.2022.2146983
31. Jain S Using social media platforms for the greater good—the case for leveraging social media for effective public health messaging. *JAMA Netw Open.* 2023;6(6):e2319682. 10.1001/jamanetworkopen.2023.19682 [PubMed: 37351892]
32. National Cancer Institute. Health Information National Trends Survey 6 (HINTS 6) methodology report. April 2023. Accessed September 1, 2023. <https://hints.cancer.gov/data/methodology-reports.aspx>
33. Scherer LD, Pennycook G. Who is susceptible to online health misinformation? *Am J Public Health.* 2020;110(S3):S276–S277. 10.2105/AJPH.2020.305908 [PubMed: 33001736]
34. Goldsmith LP, Rowland-Pomp M, Hanson K, et al. Use of social media platforms by migrant and ethnic minority populations during the COVID-19 pandemic: a systematic review. *BMJ Open.* 2022;12(11):e061896. 10.1136/bmjopen-2022-061896
35. de Armas S, Polite Corley C, Flack J, Ratulangi P. Inclusion, information, and intersection: the truth about connection with U.S. Latinos. Nielsen Diverse Intelligence Series. September 2021. Accessed September 1, 2023. <https://www.nielsen.com/wp-content/uploads/sites/2/2021/09/nielsen-2021-hispanic-diverse-insights-report-210682-D9.pdf>
36. Nezafat Maldonado BM, Collins J, Blundell HJ, Singh L. Engaging the vulnerable: a rapid review of public health communication aimed at migrants during the COVID-19 pandemic in Europe. *J Migr Health.* 2020;1:100004. 10.1016/j.jmh.2020.100004 [PubMed: 33447830]

Table 1. Survey-weighted descriptive statistics: Health Information National Trends Survey 6, 2022.

	Raw <i>n</i>	Raw %	Weighted %
Total <i>n</i>	3841		
Outcomes			
How much of the health information that you see on social media do you think is false or misleading?			
None/a little	715	19%	18%
Some	1768	46%	46%
A lot	1358	35%	36%
I find it hard to tell whether health information on social media is true or false			
Disagree	1303	34%	33%
Agree	2538	66%	67%
Demographic predictors			
Age group			
18–49y	1728	45%	60%
50–64 y	1136	30%	27%
65+ y	977	25%	13%
Birth gender			
Male	1451	38%	47%
Female	2390	62%	53%
Marital status			
Married/cohabiting	2138	56%	58%
Formerly married	888	23%	10%
Never married	815	21%	33%
USDA 2013 rural/urban designation			
Nonmetropolitan	471	12%	12%
Metropolitan	3370	88%	88%
Race/ethnicity			
NH White	2203	57%	61%
NH Black	591	15%	11%
Hispanic	703	18%	18%

	Raw n	Raw %	Weighted %
NH Asian and other	344	9%	11%
Education			
High school or less	732	19%	24%
Some college	1105	29%	39%
College graduate or higher	2004	52%	36%
Work full time (past 30 days)			
No	1700	44%	39%
Yes	2141	56%	61%
Feelings about household income			
Finding it very/difficult on present income	757	20%	19%
Getting by on present income	1406	37%	37%
Living comfortably on present income	1678	44%	44%
Social media predictors			
Frequency of social media site visits			
Monthly	529	14%	13%
Weekly	571	15%	14%
Daily	2741	71%	74%
Share personal health information on social media past 12 months			
No	3099	81%	81%
Yes	742	19%	19%
Share general health-related information on social media past 12 months			
No	2347	61%	62%
Yes	1494	39%	38%
Interact with people who have similar health or medical issues on social media or online forums past 12 months			
No	2805	73%	73%
Yes	1036	27%	27%
Watch a health-related video on a social media site past 12 months			
No	1159	30%	30%
Yes	2682	70%	70%
Most of the people in my social media networks have the same views about health as me			
Disagree	2056	54%	54%

	Raw n	Raw %	Weighted %
Agree	1785	47%	46%
I use information from social media in discussions with my health care provider			
Disagree	3029	79%	80%
Agree	812	21%	20%
I use information from social media to make decisions about my health			
Disagree	3209	84%	84%
Agree	632	17%	16%

Source: Authors' analysis of Health Information National Trends Survey 6 (HINTS 6), 2022, which accounts for survey weights and design using jackknife replicate weights for variance estimation.

Abbreviations: NH, non-Hispanic; USDA, US Department of Agriculture.

Table 2.

Multivariable analysis of adult social media users' perceptions of social media health information: Health Information National Trends Survey 6, 2022.

	Perceive some/a lot of false or misleading health information on social media		Unable to assess health information on social media as true or false	
	Predicted probability	95% CI	Predicted probability	95% CI
Age group				
18–49 y				
50–64 y	0.01	–0.04, 0.06	0.07	–0.01, 0.14
65+ y	0.01	–0.05, 0.07	0.11	0.03, 0.20
Birth gender				
Male				
Female	–0.01	–0.06, 0.03	0.00	–0.04, 0.05
Marital status				
Married/cohabiting				
Formerly married	–0.02	–0.07, 0.03	0.00	–0.07, 0.08
Never married	0.00	–0.05, 0.05	–0.01	–0.07, 0.04
USDA 2013 rural/urban designation				
Nonmetropolitan				
Metropolitan	0.04	–0.03, 0.10	0.02	–0.06, 0.10
Race/ethnicity				
NH White				
NH Black	–0.10	–0.17, –0.04	–0.05	–0.13, 0.03
Hispanic	–0.11	–0.18, –0.05	–0.09	–0.16, –0.02
NH Asian and other	–0.02	–0.09, 0.04	0.03	–0.05, 0.11
Education				
High school or less				
Some college	0.05	–0.02, 0.11	0.04	–0.03, 0.10
College graduate or higher	0.03	–0.03, 0.08	–0.06	–0.13, 0.01
Work full time (past 30 days)				
No				
Yes	0.00	–0.04, 0.05	–0.02	–0.09, 0.04
Feelings about household income				

	Perceive some/a lot of false or misleading health information on social media		Unable to assess health information on social media as true or false	
	Predicted probability	95% CI	Predicted probability	95% CI
Finding it very/difficult on present income				
Getting by on present income	0.02	-0.04, 0.08	-0.04	-0.11, 0.03
Living comfortably on present income	0.06	-0.01, 0.13	-0.05	-0.11, 0.02
Frequency of social media site visits				
Monthly				
Weekly	-0.01	-0.07, 0.06	0.02	-0.08, 0.12
Daily	0.01	-0.04, 0.06	0.00	-0.08, 0.08
Share personal health information on social media past 12 months				
No				
Yes	-0.03	-0.09, 0.03	-0.01	-0.09, 0.07
Share general health-related information on social media past 12 months				
No				
Yes	-0.01	-0.06, 0.05	-0.02	-0.09, 0.05
Interact with people who have similar health or medical issues on social media or online forums past 12 months				
No				
Yes	-0.01	-0.06, 0.04	0.04	-0.03, 0.11
Watch a health-related video on a social media site past 12 months				
No				
Yes	-0.01	-0.05, 0.04	-0.01	-0.06, 0.04
Most of the people in my social media networks have the same views about health as me				
Disagree				
Agree	-0.01	-0.05, 0.04	0.10	0.05, 0.14
I use information from social media in discussions with my health care provider				
Disagree				
Agree	-0.03	-0.11, 0.05	0.01	-0.05, 0.08
I use information from social media to make decisions about my health				
Disagree				
Agree	-0.10	-0.18, -0.02	0.09	0.01, 0.17
Constant	0.80	0.69, 0.90	0.64	0.50, 0.78

Total $n = 3841$. Outcome: “How much of the health information that you see on social media do you think is false or misleading?” Response categories were None/A little vs Some/A lot. Outcome: “I find it hard to tell whether health information on social media is true or false.” Response categories were Disagree or Agree. Predicted probabilities and 95% CIs were estimated with multivariable linear probability regression models.

Abbreviations: NH, non-Hispanic; USDA, US Department of Agriculture.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript