11:00

Jeremy: Good morning, everyone. Please take a look at your mute button on your screen or phone, make sure you're muted unless you're a speaker or asking a question so we don't have background noises interfering with our speakers. Dr. Mooring, any updates or announcements?

Bryan Fisher: Going to break in here; wanted to say, you're well aware it's national Public Health Week, congrats to all and thank you on behalf of the Governor's office and Unified Command. We might not all be full time Public Health professionals, but all crisis communicators are part Public Health through the past year; thank you for all done and continue to do on behalf of all Alaskans.

Eric: Echo that, we rely heavily on the info you put out to communities and share back to us. This is one of the important partnerships through response. Not too much to share this morning, we did have the updated Alaska Genomics Report come out on Tuesday, link in the chat, take a look. We are reporting out, for variants of concern, 5 new b.1.1.7 lineage, first identified in the UK, increasing frequency in many parts of the US. We had 2 previously, December/January, both in travelers. For our new b.1.1.7 reporting out, they are not all in travelers, at least 3 in Anchorage are cases that we are further investigating but don't seem to have an obvious travel history at this time.

Doesn't meant there is sustained community transmission for b.1.1.7. It would take more data over time to get a better sense of that, there are any number of instances where a virus can be introduced, spread a little, but not sustained. We'll continue to look at it.

Identified one for P1, a case in February, near the same time as others that were identified before. Hard to say if sure, but may be epidemiologically linked between this and others. It's reassuring that no more P1s were identified in March sequence data.

Most sequence data is more recent from March, lab focused efforts on more recent cases.

Did find a b.1.351, also in Anchorage, that is the lineage in South Africa, and has been a source of some concern, seen in many states in the US, not as prevalent as b.1.1.7. That there's no travel history is concerning, doing more research.

That's the update for the three variants of concern that we do extensive investigation for. B.1429 was found, first identified in California, many of those are occurring in interior Alaska as had been the case before. That is not a fundamental change from what we'd previously been seeing epidemiologically.

We continue to work on these cases to learn more about them and to generally look at genomic epidemiological data.

Other thing, somewhat related to variants of concern, also to vaccines, posted a link to the chat though its been shared previously, CDC science brief about recommendations for fully vaccinated persons. It's a long document, I encourage people to read it, addresses in detail our current understanding of a lot of issues around the effectiveness of vaccines not only symptomatic disease, but infection/infectiousness, issues on what we know/don't know on vaccine performance against variant strains. A few things on popular attitudes/measures on vaccination. Polling on things that might motivate people to get vaccinated, like not having to continue non-pharmaceutical intervention, then discussion on vaccination, testing, and travel.

It relates to many of the questions that come up on these calls.

That's all for this morning. Will be back early next week with further discussion with trajectories and what we're seeing in Alaska for cases. Can drop cases in chat for today, broadly in line with what we've seen in the past days.

Turning over to Elizabeth or Regina or other folks. Thank you all.

Regina: Thank you. I am going to open up--on the agenda we have Sarah Aho and maybe Jessie Barker who can talk about the statewide survey on vaccine motivation/barriers and what it means for messaging, earliest look at data, and then we'll also have the APHIRT, Dr. Meyer on insights, statewide social media, and then we have Dr. Joy Mapaye on some efforts to reach specific audience segment.

Sarah: (shares screen Statewide survey Results) I know you've heard about the survey for a couple weeks/month, and we're excited that we have things to share. Statewide phone survey, reached 1,256 participants, over 50% had already received at least one dose of vaccine, or an appointment. We expected this by rollout (percentages by month) Great news. Also great news Ease of finding process, majority who'd already done it found the process easy.

Of those who haven't been vaccinated, intent to vaccinate (pie graph), 26% definitely yes, 52% definitely no, 22% not sure. Intent to vaccinate, how to move them from definitely not to definitely yes (display). We don't know where in the Probably not or Definitely not, might not want to say. We do know 73.3% of not yet vaccinated are probably not on down. 36% of total sample population, mirrors national at 30%.

We want to look at everyone who is a little unsure of vaccination, want to learn more on vaccines, want to help them learn more an answer questions. Rest of slides focus on the unsure who are open to learning more. Their top 5 motivators: help protect friends and family, get economy back on track, I won't have to quarantine, will help return life to normal, vaccine shown to be highly effective.

3 top trusted messengers; family friends, healthcare providers, and CDC

Final info: Agreement percentages to statement on covid vaccines, high agreement on individual responsibility and protecting others. Less on it being a community effort, or an important tool with ending the pandemic. Low agreement on vaccine preventing illness or death, the vaccine is safe, and all vaccines are as good as each other.

Demographically, we're looking at a lot of younger males who are unsure on vaccination but interested/open to learning more.

Those are preliminary results, we have a lot of work to do still, many thanks to the UAA team, helped with analysis, will do again this month, looking to developing messages around the topic, more to come, thanks.

Regina: Thanks Sarah and Jessie, any questions before our next presenters?

Lauren, PHN Homer: Curious on the confidential breakdown of data, will that be made available to local Public Health Nursing, like other communicable diseases?

Jessie: Can you clarify what kind of breakdown?

Lauren: Very specific data by zip code or CDP to PHN, stuff that we might not be made available to the general public?

Jessie: The concerns with making zip code level, at granular level, is the sample size issue, also identifiability; they're pretty small numbers from some zips. The info inferred from data at so small a sample is not reliable. We're still kinda thinking about the best way to categorize things; if there are specific pieces of info that would be helpful to you, get in touch with us and we'll see what we can provide.

Regina: I think we're looking at regional breakdowns by public health region, where the sample size is large enough. I think it would be useful to consider how they go hand-in-hand with additional analysis on the local level, qualitative where it might be needed. This does have some limitations; the way it was disseminated; digital survey, so if looking at barriers for specific pops who have less technological access, that might be--yeah, there's a lot to consider/have more discussions on in future calls.

Eliza Mews: Question on survey, were there questions aimed at parents around attitudes on vaccinating their children once an EUA might happen, get a sense of what they're thinking about childhood covid vaccines and whether obtain them for their kids

Sarah: there were no questions about that on the survey.

Regina: We did ask a question about demographics about households, so if there's children at home we might see it, but nothing on routine childhood vaccination

?: Is that something we might be interested in for future surveys?

Regina: I think that's a question for Sarah or Jessie--

Sarah: I think that would be of interest since we know that covid is in the trial phases for children and would help to know what uptake would be like in that circumstance.

Regina: Thanks so much; note that, this is the tip of the iceberg in what was collected. Jessie and Sarah are looking at cross tabulations, strategically how to capture the most with the frequencies available. I don't know if there's any additional--I see a request for the survey slides, will include it in the email from Debbie McDonald, with the summary email.

See a questions from Marmian that Jessie or Sarah might answer--in the chat.

Sarah: I see and I'm writing back to it. We don't know how many refused to answer the survey; texted.

Jessie: Reading the question as well. I don't have that data, but our contractor does and he—we know he had people drop off partway through. When people don't respond, don't know if it was an invalid number or no response, but does have data on those who started but didn't finish. People who hadn't been vaccinated were more likely to drop off partway through than those who had. That doesn't seem surprising to me; people who are vaccine hesitant wouldn't want to spend time answering another survey about it, but I don't have specific data on it.

Regina: Thank you Sarah and Jessie, I'm going to hand this over to our next presenter, Dr. Jennifer Meyer, with APHIRT insights on misinformation.

Jennifer:; Joy, did you want to go next?

Joy: We can present the slides now, and then I can transition back to you, Jennifer. Regina, do you have the slides from this morning?

(Display)

Joy: Hi, I am Joy Chavez Mapaye, about this time last year Tom Hennessey put together the team for data/research for Muni research.

First survey in May, population based, 1k goal, series of panel surveys, phone survey, more panel surveys, tried to anticipate needs in covid response, questions on masking, mandates, gatherings, etc.

Produced a series of briefs with the findings, which are all on the Muni covid data dashboard, now in message evaluation part of project, with the expanded evaluation team.

Now working on aim three, Message evaluation component, strategies, and assisting in creative asset development. Tasked with identifying vulnerable demographics, making and testing messages. Informing message roll out, first group identified was conservative men, 35 and younger, consistently reporting being more likely to engage in covid 19 risk behaviors.

Identifying target population for messaging: Identified as politically conservative, 98% less likely to get vaccinated. Three times more likely to be in close contact, crowd, enclosed areas, and 6x more likely to engage in three or more risk behaviors.

(Reads from slide further risks)

To help with that, we partnered with UWIT communications, make draft of patriot themed, get the shot (display meme). Trying to incorporate in a social graphic.

Other message is, we felt there wasn't enough messaging on Long Covid, specifically since the target is young men, decided that one of the message components to highlight is ED, how they're finding in research that it can be a long covid issue, so informing in messaging. Since target audience is young, conservative men, so (display meme). Text will accompany with issues on long covid. Because we were incorporating memes, we developed other memes; drake meme, others that are familiar with younger demographics.

Meme concept related to long covid and adding descriptive message to convey the point.

Other concept would be the idea of making both vaccine and the idea of engaging in covid mitigation behaviors, wanted to make it more appealing, in this case, something appealing in terms of data-- (silenced briefly) -- the one that's most appealing happens to be the young man with the mask and band aid on his arm to show that he's had his covid 19 vaccine.

Guess we're ahead, we developed this in January, and there was an article on covid vaccination and data, 25% to 30% increase in mentions of vaccines in dating profiles. In tinder itself, reported 258% increase in profiles mentioned related to the word vaccine. We feel this is something many are thinking about, and this is one way to appeal to the demographic; dating sites are expecting even more interest over time.

Next steps: Focus groups: JBER, March 10 and 12. We asked what was appealing/continue to develop/refine, part of the issue with the patriot concept was person out of regulation. That was one thing we've noted to refine in messaging, developing other social graphics. Some memes didn't play well with the focus group, little john one confused them, drake was popular, appealed to that group. Developed new meme concepts related to Oprah and the interview with Megan and Harry, going to use as part of focus group

In addition to feedback, intend to have message survey late April/May, related to meme concepts, and then next target population conservative women.

In terms of vaccine hesitancy, women were more hesitant compared to men.

Some of the things we're trying to do and think about in next steps.

PR/Marist Poll: though we're targeting conservatives with messaging, latest NPR, 1 in 4 Americans would refuse the vaccine, 5% undecided, although numbers are highest in republican men and residents of rural areas, still a significant number across all age/demographics.

Vaccine hesitancy is a big problem for all of us.

Health misinformation: misinformation is targeting different groups; we need broad, grassroots effort with local leaders and groups. Misinformation is organized. This blanket approach needs to be one where we're speaking to different groups; interpersonal communications level, group communications, in addition to public communications efforts.

Questions? Otherwise, to Dr. Meyer on the other APHIRT efforts.

Dr. Meyer: I threw together some slides very quickly, ask forgiveness for quality. (Shares slides) Big picture, drill down to details. Misinformation on social media can be viewed as contagion/vector for vaccine hesitancy. In 2019, was named by WHO as one of the top ten Public Health threats. We're up against a monster. Looking at the data, in terms of percent of some community's vaccine uptake, we're seeing variability, some low uptake, others great;particularly tribal.

Have some work ahead. Background, understanding risk communications and combating communications, link to site on how social media fuels vaccine hesitancy. All of you are important interventionists. We need to intervene at multiple levels, have to help clinics provide info, shift community norms, data shows highly conservative areas have strong interest in not getting vaccine, so how to shift the cultural norm to be more acceptable or vaccination. Removing barriers to access.

Media, social media, are extremely effective, can address all those levels; Individual, community, policy, saw in legislative sessions in Juneau, provided info to combat misinformation at the policy level.

In Public Health, Understanding the threat; root causes in misinformation and why it's effective. CBC marketplace attended a covid 19 conspiracy boot camp, and I'll send these slides out for the hyperlinks, video from well-known propagandists, $625 per person boot camp, 400 students, what was revealing is how deliberate and organized and financed antivax is and how their leaders manipulate and propagate misinformation by working with people on the ground to influence their views on vaccination. We need to share information about this.

Another link to the most common disinfo propagandists.

In the vaccination world, we know them my name, (examples), a handful I can rattle off the top of my head. We're going to run into vaccine hesitancy fueled by misinfo.

National Gallop poll, 1 in 4 refuse the vaccine or are hesitant.

We see this in Alaska. Conquer Covid found a target group of 37%. Then the asked further, what was driving their hesitancy on vaccination. We saw issues on letting others go first, rushed, not tested, "I'm low risk covid won't hurt me"--Wasilla and Mat-Su, hear that a lot, we--need to address that death isn't only negative outcome, 1 in 3 have long covid symptoms, revealing that might be a good message. Aborted fetus message on social. Vaccine will give disease, common issues in hesitancy, similar to the national poll.

Themes on safety, don't think the disease is serious, vaccine was developed too fast.

Lots of our messaging is fact-based, and maybe we need to shift to these common areas of hesitancy.

How does that overlap with APHIRT observations from AK facebook? Lots of similarities; (Lists) And the antivax orgs are also looking at this info, identifying what are the issues for individuals on the fence who maybe haven't made up their mind yet, and how can we continue to spread seeds of doubt about vaccine, which is their aim. If you look at CBC article, it's well explained.

Lastly, I will close with what can we do; responding and debunking, pre-bunking. Timothy Caulfield has done lots of work, links with his materials, Peter Hotez is another hero. Antivax has wedded itself to populist political movement, might be the reason we have so much hesitancy with those who identify conservative, and these articles identify why and why that's dangerous.

In debunk/prebunk, important to develop a skillset; not enough to talk about science, which is hard because that's what I talk about. It's not enough to just fact check. Important to understand why misinfo is so effective/sticky and why persist after debunking false claims. Think about how important it is to debunk often and properly.

Something I've worked on as misinformation responder, revealing money behind movement, who the grifters are, and helping readers who use social media protect themselves by learning to identify it. Someone mentioned in chat recently that we're going to see unpleasant stuff as pediatric vaccination becomes approved, or EUA. We'll see the ugly misinformation that we tended to see around pediatric vaccination from the antivax movement, including unpleasant, emotional images, disturbing, that tend to persist after debunking.

Whatever we can do to prepare ourselves, prebunk with audience that these are common tactics and how to anticipate and protect self and Identify misinformation online as they are consuming media.

Several of you are probably already aware of misinformation handbook, links I can share; it helps me frame my responses in a way that I think will be more effective. New resource Made to Save, promoting covid 19 vaccine. I will send the slides to Regina to share.

But this is what the information response folks are training on with volunteers. Encourage everyone who wants to help to join us; all of us are volunteers, responding on our own time, with warehouse of resources.

Info from the chat that the resources might be useful, and if you think of things that help us debunk false claims online. Reach out to me, helpful to talk anytime.

Joy and I can take questions.

Regina: Thank you Joy and Jennifer. I do see a question from Derotha, facts and resources around ED, Dr. Mooring might have more to add

Eric: Dr. Mapaye and myself have been putting links in, it's an emerging area of research. Study I dropped in is peer review, in a medical journal, does in the analysis, account for age, BMI, as well as a few psychometric risk scores that might be important predictors of ED independently of covid. Expect more research going forward, but some evidence of emerging risk.

Derotha: Thanks. I read that article, clicked through to the Cleveland Clinic; me reading it, I'm not a clinician, lots of unknowns in this, and those folks might have been on the train to begin with. In the vein of making messages bulletproof, want that one in particular.

Eric: Appreciate that

: framing it as people think covid is benign, there are pathophysiological reason why men might complain of ED after infection, how long it lasts/whether predispositioned, however, it's been a common complaint amounts those infected. Help people understand covid infection not is not benign,

symptoms can persist for 1 in 3 or 1 in 4; study just yesterday on continued fatigue/depression and mental health.

Speaks to an area where people think most don't have symptoms; might not be true, and these are things that people might complain of after recovery. Works on social media, speaks to men at their core; issues where there are long term or after recovery

We're learning more about long covid and effects all the time.

Regina: Thanks so much. Also question in chat on any upcoming resources to support communications on long term effects of covid. Maybe Dr. McLaughlin highlighted--he's no longer on thec all. Maybe Mooring knows more on the effort

Eric: I'm not aware of anything specific to the website; Elizabeth had to drop off as well. We can circle back on this. There either is or will be more CDC guidance on the various post covid consequences, medically complicated set of things with a wide range of presentations, will see what more information we can find for next week.

Regina: Thanks, and for those on the long term impacts; vaccination and being common questions that people have expressing concerns about the vaccines having long term effects they can't see, it would be helpful to communicate the real and known complications that can come from covid long term.

Any questions from chat? Closing thoughts?

Lisa in Juneau: follow up in Christine's question, regarding the semantics of approved and authorized and how that seems to be a huge sticking point in our research so far. Christine was looking for a step-by-step comparison of the EUA process vs approval process, the language around no steps skipped. She's looking for that online, what's FDA process for EUA and normal? Is there anywhere that has a side by side on that?

Eric: I can take the question back. I was searching here while listening to see if I could find something clearly labeled. Will see what we can find; Coleman Cutchins is involved in the response, may be able to help communicate things on this. Definitely a complicated issue made more complicated by FDA putting out guidance before the vaccines applied for their EUAs, when they were doing trials, about what sort of leveled evidence they would look for, and it was stricter than was necessary for a EUA. It's been between EUA and full; we'll see what we can find.

Lisa: Thank you.

Regina: Any more questions from those on the call?

I think we can go ahead and close. Thank you so much to Dr. Mapaye and Meyer, and for everyone joining and sharing insights/thoughts. If you'd like to present on a future call, something to share, go ahead and contact me for the Thursday calls where we focus on vaccine, or connect with Elizabeth for the Monday calls. I'll put my contact in the chat, see you next week.

Eric: Thank you to everyone on the call, talk to you Monday.

Call ended 11:56