

Live Captioning by AI-Media

SPEAKER:

Hello, everyone. Thank you for joining us for this first in a four part webinar series presented by UCLA and hood medicine. This is public health munication 101. You should have come in the room already muted, if for some reason you are not please minimize background noise and mute.

I am project communications assistant at AUCD. I will be logistically helping out along with my colleagues. Your main presenters today are Emily Hotez and Neecey Hudson. A couple of quick housekeeping notes.

Your camera, you can have it on or off to pending on what you want. You should be muted. There is a captioner in the room. If you need closed caption all you have to do is go to the bottom right corner where it says closed caption and click that button. If for some reason you have logistical or tech support needs or questions or are coming up with issues you can put a message in the chat and Anna and Charisse will be able to help you.

This is being recorded, just so everyone knows. With that I will turn it over to Emily and Neecey.

DR EMILY HOTEZ:

Inc. you so much. Thank you for joining our workshop series. I am a developmental psychologist and researcher. I'm thrilled to be joined by my colleagues today, Doctor Neecey Hudson, chairperson at Wood Medicine Initiative, and I'm also working with a wonderful UCLA student who is a leading member of a UCLA student group called neurodiversity Health Chats. Together we are thrilled to have you for our first workshop.

This is part of a four-part virtual workshop series on inclusive public health communication. Our next one is May 2 at the same time. Today we will focus on public health communication 101 during and post COVID for neurodivergent and other marginalized populations. As all of you are well aware, having an intellectual or develop mental disability was among the single biggest predictably of contracting and dying for COVID-19. In all of our monthly webinars from now until July we hope to equip you with knowledge and skills to be an effective public health messenger to address health disparities for the population that were unfortunately not defined during post COVID-19.

This series is, as you know, funded by a joint cooperative agreement between AUCD and CDC.

A few notes about the surveys we asked you to participate in. Please know they are entirely voluntary. They will help to make sure the content we provide you with is on par with your interests and priorities. It will also really help us to further develop this workshop series and foster more effective public health

communicators among those who serve disability and neurodivergent communities.

I know so many of you here today either identify as neurodivergent, or have a family member or close friend with a disability. As the sister of an autistic adult I share your professional and personal commitment to our work today.

I will put my email in the chat. Anytime feel free to reach out with any questions or ideas after our workshop. In general, this is a workshop not a webinar, so we are hoping to interact with you and meet you, and learn about your goals and your work.

Please don't hesitate to write in the chat throughout the workshop.

I'd like to turn it over to my team to introduce themselves. I am not sure if assault is on. If so if you could introduce yourself. If not we can turn it over to Neecy.

DR NEECY HUDSON:

We will see if she can jump in when she gets out of class. My name is Doctor Neecy Hudson. Instructor of Hood Medicine thank you for having us today. I have been working with Emily and UCLA and their new group, neurodiversity health chats to develop an inclusive community centered equity focused public health munication's-- communications for neurodivergent populations. We want to share some insights today on the work that we've done.

Again, when Asal pops on hopefully we will be able to introduce her as well. Emily is going to drop this link in the chat for everyone. We wanted to do a quick check in and get a short response from you about what makes you stop and click on social media.

Whether it's infographics, imagery, or especially with COVID-19 different news articles and notices. What makes you stop and click when you are scrolling through social media?

I'll give you just a few moments to do that. Once you have completed the survey, if you wouldn't mind, I see we've got some comments in the chat as well.

A good headline, eye-catching image, keywords. Keep all those things in mind as we go forward and pass communications and credibility sources, imaging.

We will collect those results from the survey as well.

So, we wanted to start in this first workshop by giving you some grounding in some of the foundational communication theories about behavioral change and patients, and how to advocate for people to

either adopt certain preventative behaviors, or change in health lifestyle in order to promote reducing the risk or increasing health and wellness.

Certainly a lot of these aspects of behavioral health and psychology, social science, and just things we know to be true about human nature and employ that as well. Emily, I don't know if you want to say a bit about what that looks like for this particular target population.

DR EMILY HOTEZ:

Absolutely. I will say something that has come out of my work with Hood Medicine is there are things we can glean from communication with diverse marginalized populations. While the neurodiverse should be community are unique and their needs there are certainly other marginalized populations who perhaps share some similar needs with neurodivergent communities.

That said, we know that individuals with certain disabilities may have particular mistrust of medical establishments, particularly related to vaccines, and so sensitivity to vulnerable populations, or populations that may have been exploited in the past would be an example of a specific factor relevant for individuals with disabilities.

I also have perhaps, certain sensory needs, certain educational or support needs, all of these things can be taken into account.

DR NEECY HUDSON:

I will start with one of the oldest models and run through these pretty quickly. This is one that's called information motivation behavioral model. The reason why it has been sort of revised and we've added a lot of nuance since it first was introduced is because it presumes that all of these factors are sort of independent constructs and as long as people have the information they need and the motivation to do that particular inventive behavior and the ability with behavioral skills that automatically blends toward behavior change.

Which, we can see from the pandemic, things are not that simple at all. Especially in an age of what's been coined infodemic and random disinformation. Especially targeted, obviously vaccine hesitancy has been an issue arising in the autism community because of the debunked paper. That's always going to be a challenge.

When you add on the intersection of different marginalized communities who also might have had histories with medical human rights abuses and unethical human experimentation it's very easy to see why the messaging has been so complex around the pandemic, and why there's been such widespread resistance for different reasons among different populations.

That kind of evolved into the health belief model where it posits that as long as you have a desire to avoid illness, or a belief that that particular action it will prevent or cure it that will set you on the right path sort of thinking about it and hopefully motivating you to achieve that behavior. It kind of starts with this perceived acceptability. Am I at risk? What's the severity? How bad would it be if this happened to me?

And then moving into sort of a consideration of perceived benefits of the proposed action, and then also whatever barriers that particular individual has to accomplishing that behavior scale.

And then of those contemplations lead into the Q2 action.-- cue to action. A self-efficacy piece where you have to be able to maintain that new habit or lifestyle, or whatever it is that's being advocated in order to reap the benefit.

And then you have the theory of planned behavior. This one is about intention, and again efficacy. Do you have the ability, and then once you start a certain behavior can you keep it up? It looks at attitudes towards the behavior, which I think is especially relevant for the pandemic because of misinformation, and also so much mistrust of government and health institutions. There's various attitudes from lots of different communities about vaccination, preventative behaviors like masking and social distancing. I would hope that at this point we would understand that with the emergence of a brand-new variant every time we take our masks off that's giving the virus a new host to jump in your mouth and mutate again.

Those are the kinds of things where you have to marry some of the basic science information and health information into the person's understanding of the benefit and the risks of certain behaviors. And then also kind of put it on a level.

I know for us we like to really just keep things focused on really practical themes like spit and just the natural aversions that we all have towards germs and spreading disease. Which I thought would be enough, but obviously it's not for this pandemic.

And then it also kind of considers these norms. Things you feel like influenced by your environment. The blood the grocery store masking up, still going out to parties, or still doing this. What are your perceived norms? And also what's really going on? All of these things lead to intention and whether you feel like, again, you have the power to change your behavior and action, and whether you can sustain it with the self-efficacy.

And then you have the stages of change model which starts to put things in a more reasonable context in terms of how we really think about or work through different choices. There is this conceptual cycle, but you can sort of go in and out at any stage. Basically you start contemplating what the action is, you

build a determination to make that change, and then you have the action phase, which also has that maintenance or self efficacy step. Again, you can fall in and out of these. Which, again, we are seeing with the pandemic when it started we all were so frightened and unsure that everyone was a lot more likely to adhere to the social distancing, lockdowns and the masking. As time has gone on and there has been lots of different things to contemplate, and different influences of our environment that have made our adherence to those actions kind of wax and wane at different points.

I guarantee if you match it up with how the different ways the variance wax and wane they would be in-
- superimposed on each other if I had to guess.

And then the social cognitive theory. It brings more weight, the impact and influence of your environment and your peers. That learning is dynamic and interactive. You have this behavioral capability, but you're still looking around, like what's going on around me, what are other people doing? If I start to consider this behavior can I do it? How do I do it? It takes into account reinforcements that you need from your environment. Whether in the digital age that's pings on your phone, or just constant sort of recycling of different messages, there's an expectations piece where you are considering what's expected of me, which again, speaks to the norms of society one is considering.

And then again the call to action and self-efficacy of whether you can keep that behavior going.

And then in terms of expanding that influence model. The social norms theory is all about the environment and interpersonal interactions, and how. Influence changes your behavior.

It posits that it's all about perception. Your perceived norms and actual norms. This is where you can really kind of have an influence in terms of social media campaigns where you are starting or your aim is to create a groundswell of changing people's attitudes about certain things, which you can try to do. Hit people over the head or try to chip away subconsciously at whatever beliefs they currently hold.

Which is what we like to do. Try to introduce doubt into the things that we know and some of the misinformation that is propagating throughout various communities.

This theory really talks about everything that's kind of influencing from the outside in.

And then, of course like most things, the diffusion of innovation model. It conceptualizes this change across society as a bell curve. As most things are. In this case this guy is definitely me running to go get my vaccine when it first came out. And then of course there's people all along the spectrum and temporally where they started off immediately just like lined up waiting for the vaccine, and people now are still really resistant and it's hard because it's really politicized, and again in terms of perceived

norms and environmental influence you can't necessarily divorce peoples, even their political influences in this case what they believe or not to be true about potential health risks and benefits, MC seen.-- As we've seen.

It's important when you're talking about vulnerable populations who are medically disenfranchised and already had a lot of issues and barriers with lack of access to resources and the same sort of ability to perform the behaviors. A lot of things we are talking about our personal choice, and people necessarily can't socially distance the way one would like to decrease the spread of an airborne virus. There's people who have different barriers in their sort of other environmental aspects in terms of socioeconomics, transportation etc. where we are seeing their bearing the brunt of negative outcomes of the pandemic.

It's really an fortunate even-- unfortunate for people at the most risk we are not done a great job of moving the needle. They are still staunchly resistant segments of our society that I suspect are a big cross-section of intersectional identities within it.

I was going to throw it over to Emily for second to introduce how we built upon all of these foundational model skills our messaging framework that we published recently, and clinical medicine. I will drop that link in the chat if anyone's interested in that. Emily maybe you can speak a little bit to how we use that to influence to prioritize messaging.

DR EMILY HOTEZ:

Of course. Please do not feel overwhelmed by this very complex info graphic.

I think even just looking at this from a Birdseye view gives you a sense of how complex and layered it can be when communicating to marginalized groups. But generally speaking we understood and were thinking about public health messaging we need to consider individual level factors, interpersonal level factors, community and societal level factors.

Individual level factors could span things like social determinants of health. It could also span things like behaviors, self advocacy capacity for example would be an individual level capacity that I would want to consider. Interpersonal, that refers to interactions between people.

We know there are various barriers and facilitators at the interpersonal level. When such barrier could be experienced or anticipated, stigma through social interactions or with healthcare professionals etc. Community level factors. We know that there's differential access to vaccine and COVID information. Societal level factors have, of course, we are well aware of structural inequities that affect quality of care and access to public health interventions.

We wanted to capture all of those complicated levels of influence when it comes to actually reaching our target population. If you scroll your eyes on over and look at messaging segments we conceptualize the idea that there would be four strategies for trying to get at all of these interactive and complicated levels of influence.

These are all things that Hood Medicine does. And hopefully at the end of this workshop series you will have a higher capacity to be able to do yourself. Things that make infographics that speak to interpersonal level barriers, engage your community in a way that is reflective of the heterogeneity within individuals that you are trying to reach.

And then we scroll all over to the right. Communication and outcomes. Neecy can speak more to the outcomes. That's a big part of Hood Medicines framework and overall work. But essentially we think that if your messaging segments are really speaking to these interactive levels of influence you can promote awareness and information, you can increase preventative health behaviors, and establish trust and credibility with your community, which is essential for all of this work.

DR NEECY HUDSON:

Some of the things that we, as you can see there, we try to build different lens messaging. Some is infographics where we have some sort of science or medical information to convey. We want to break that down. Even within those we try to still use vernacular, linguistic, visual themes and cues that we think will resonate with whatever subsegment that we are targeting as well.

But then we also, in addition to health advocacy and explaining what people need to do and why, we like to do engagement pieces where we just kind of telegraphed to the audience either ally shipped, or belonging to their community. At the very least that we understand their issues, and also why and how society is set up to perpetuate them. I think that's something that's really important because I think a lot of us publicly speak academically about health disparities, and there's been a lot of, certainly, increased spotlight of late. It feels like it's definitely a frame of reference of the patients, or the patient population.

There's not much that communicates to the patient that anyone understands that it's a structural or institutional issue. Even just recently the (unknown term) Journal had a podcast about racial bias in medicine. They basically purported there was none.

Individual care providers weren't racist. How could there be a structural issue? I think that's part of the problem is that no one individual provider is going to diagnose themselves as having a bias, however it's clear that people in these communities, we hear the same stories over and over again they are having horrible, humiliating experiences in the exam room. That's just their life.

It's hard to reconcile the two. If there's no physician who perpetrates this on their patients than I don't know where all the complaint are coming from. But for many people the face of this broken system is there care provider.

I think it's important to communicate an understanding of the challenges. (indiscernible) if you can't call a thing a thing, which is really hard in this day and age. We don't use euphemisms, we don't dance around issues. If you want instant credibility and trust then you have to be truthful about reality. That's what we believe. There's plenty of things to communicate. For us that means CDC guidelines, the science information resources and services, and also, again, the actions people need to take to keep themselves safe in advocating for those behaviors.

A lot of the barriers we've already spoken to are clear, and I think they've been clearly defined throughout this time. I just think we all need to find a way to translate that, and the way that resonates with people, and think the most important piece of that as I was saying, we can't just keep analyzing health equity and not hold institutions and their members accountable for the actual harm that's done to these patient populations.

That's very necessary to communicate in messaging, but certainly as the missing piece in health equity overall right now to me.

The first breakout rooms we wanted to to get you guys kind of talking a little bit is trying to think about your audience, again as Emily reviewed we tried to look at it from all angles individual, and then also the individual's environment which includes interpersonal interactions, as well as society at large, and the systemic influences.

In our case this is COVID. You have individual beliefs, customs, and different predisposed conditions. All of the things that one person could be. And then also interpersonal of course, that includes your family dynamic and social and professional dynamics, which could be dysfunctional, difficult to maintain for some sub segments depending on the particular challenges and community, and whether you have support structures or access to resources and community. In society at large as well.

For the first breakout room we would love you guys to think about your particular audience and obviously they won't all be the same. Maybe just making some general considerations and have a quick chat about what are some of the top barriers for those audiences. When you get back we will have a couple of you give us some feedback about what you discussed.

DR EMILY HOTEZ:

We recommend when you are thinking about your target audience try to challenge yourself to be as specific as possible.

I know for example many of you serve individuals with disabilities across their lifespan. How much more specific can you get they can about your target population? Maybe that means considering your region, the resources the typical patient population has. Really getting granular. That can help you to think through some of those barriers a little bit more.

I will break you out. I will also introduce yourselves to each other and make a new friend.

SPEAKER:

If anyone needs captioning raise your hand using the reactions tab to the right so we will know what room to put you into retaining captioning.

SPEAKER:

If anyone needs captions there's directions in the chat. I guess we can start with introductions. I'm Sandy. Am a lecturer at the University of Maryland. I'm involved in a COVID messaging project, but I also teach a class and social media for public health students. We talk about disability and creating accessible materials. That's really why I wound up.

SPEAKER:

My name is Kari, I am in Oregon and work for public health for our county. I'm just curious about learning more about messaging, not specific obviously, just to developmentally disabled and just a special population groups.

SPEAKER:

My name is Cara, public information officer for health department in New York State. Very large upstate County. I was happy to see some of those models presented earlier in the webinar, and also looking for ideas and strategies to reach some of our more vaccine hesitant populations here in our county.

SPEAKER:

We had questions we were supposed to be answering. Was it like, who's our audience? And barriers.

SPEAKER:

We are in a pretty rural community. There's a lot of mistrust of public health in general. Messaging.

SPEAKER:

In the COVID project I am working on we are working with for, essentially counties in Maryland. Some of them are groups of counties, but a lot of them are rural and it sounds a clear facing a lot of the same issues.

Distressed, they don't think the virus is that bad, they are more afraid of the vaccine than getting sick, they have a good immune system. Those are some of the things that we've seen.

SPEAKER:

In my county we have a mix of urban, suburban and rural communities. I think there is a lot of that mistrust also of government and government agencies. I think there's also the difficulty when we communicate out, just talk to your doctor. There is a significant portion of people in our community that do not have access to or haven't had any sort of relationship with a physician so that makes things challenging. If we are telling people to go to trusted sources of information like a doctor and they don't have one.

SPEAKER:

We also have good experience here where sometimes doctors are giving good information either.

SPEAKER:

That's a good point too.

SPEAKER:

There was some confusion about sometimes the Oregon Health Authority would say something a little different than CDC. I don't know if that was your experience too. That was difficult.

SPEAKER:

We've tried to take steps to make it more accessible to people. Anyone in our county can call a phone number, call center or be able to have a vaccine scheduled for their home for a first, second booster doses we will come and vaccinate anyone anywhere in our county. Also setting up pop-up sites and mobile clinics with both a van and an RV throughout the county.

Specifically this spring hoping to hit some of our ZIP Codes that have much lower vaccination rates.

SPEAKER:

I can't imagine trying to schedule home visits. Are you getting a lot of uptake on that?

SPEAKER:

I mean, a lot is elderly people or people with disabilities who can't get out, especially during winter time. We've contracted that out with two different agencies. One that takes the north half of the county and when it takes the South having-- half. They coordinate so it is town by town.

SPEAKER:

Is that within ambulance service or hospital system? I'm just curious because we've had a tough time getting to our homebound population.

SPEAKER:

I don't know the finer details of the contract but I think it was some sort of home (indiscernible) agencies.

I'll also say we put that information out (indiscernible) especially last spring through our Meals on Wheels service locally. That went to their monthly statement. It wasn't necessarily the person who was giving Meals on Wheels, it could've been there tear caterer got that-- caretaker who helped schedule it.

SPEAKER:

That's a great idea. Looks like our rooms are closing. Nice to meet you all.

DR NEECEY HUDSON:

We like to use basic tropes like just play on people's general germ phobia type themes because it's like, we try to extract as much of the power from that other stuff as we can, and we focus people on the battle of the species that is. Focus them back on the fight that we have with the virus. Which is not always easy.

It looks like everybody is back. Asal, do you want to see what everybody had to say?

SAUL NEWMAN:

I'm so sorry. I thought genuinely this was at 1 o'clock.

DR NEECEY HUDSON:

Are people still in the groups? Am I reading that wrong? I

SAUL NEWMAN:

I think people still are in groups.

SPEAKER:

It is closing. They've got 50 seconds to leave.

DR NEECEY HUDSON:

Maybe we should hold off for a quick second.

SPEAKER:

I got invited to another room. I should not be going into that, correct?

DR NEECEY HUDSON:

No. Everybody back? Sorry about that, guys. Go ahead. A

SPEAKER:

I did work with Doctor Hotez last summer at University health chats. It's a social media campaign that was started to increase vaccine confidence in the neurodiverse community. I'm looking forward to seeing what everyone has to say.

Is everyone back or are we still having problems?

DR EMILY HOTEZ:

We are back in action.

DR ASAL BASTANI:

Does anyone care to share what they have talked about in the chat?

DR EMILY HOTEZ:

Feel free to raise your hand. Lots of rural populations, legislative pressures and misinformation. Lack of Internet access. Monica, please share.

SPEAKER:

This is Monica. I thought I will be brave because I know how hard it is to facilitate a workshop, so it's always nice. For my work my populations of focus are the people of Oregon, because I work for a state agency for COVID communications.

We don't necessarily create individual mass strategy for communications for each individual group, which I think inherently creates gaps in itself and is a barrier. Aside from political, social and ideological considerations when creating those strategies we have to think about accessibility of the documents.

One thing that came up for us about people with disabilities. Screen readers. Webpage and documents we designed were not necessarily accessible because they were not able to be read by screen readers because we hadn't put in the proper settings to have it done.

That was something we had implemented pretty quickly to adjust and fix, but when we'll have constant

change that's moving it's easy to fall back into a routine where you are not putting in those settings for screen readers in particular.

And then the other thing we found to be a barrier was when you are an able-bodied person designing graphics you are considering color pallets, feelings and colors, but you're not really thinking about how that's viewed by a person who may be colorblind, or maybe overwhelmed by the visual itself and that's also something that we've tried to integrate into by putting in more of an equity review in the process, but obviously things still fall through the cracks.

DR NEECEY HUDSON:

Thank you.

DR ASAL BASTANI:

That's a great response.

SPEAKER:

We had a good group of people. Two of us work together so we were kind of on the same plane. We had an individual from the CDC as well as a student who was working with age 17 and older parents regarding the COVID vaccine.

Our challenges were for the individual with the CDC they disseminate information, but don't know who is reading it or is accessing it. Very difficult for her to explain what the target audience is.

With our organization as a nonprofit we have some barriers and challenges reaching our lower income and outer lying areas. Number one, because of accessibility, but also language. We are working on that and have several interpreters with us now on staff. Also the other barrier in challenging and reaching students and families was basically the same thing that our nonprofit experiences with a young lady serving as a student.

Some of our barriers were resources, education between service providers and families. Time, habit formation. That's a big component as well as trying to reach those individuals might not know that you exist or have that education or information to perceive it.

Those were some of our challenges and barriers.

DR NEECEY HUDSON:

And then Lori.

SPEAKER:

Hi, everybody. I'm Lori Kramer, Executive Director of the autism Society of (indiscernible). I see a number of my colleagues in here as well. Our target population is individuals living with autism including their families, parents of children with autism.

I think that our barriers, yes there's all the ones that have already been identified which are logistical barriers, but I think with this population in particular there's a lot of mistrust, there's a lot of trauma within the medical community and a lack of trust with doctors for a lot of reasons. I also think that our messaging has to back up to meet people where they are. I think observation only some of the headlines are we know these individuals with intellectual disabilities are more likely to get COVID, like he started out saying get COVID and die from COVID.

I think people feel like that's fear mongering and you're just trying to scare people into the vaccine. I think we got to back it up and walked through why that is. I think that's where you get your peer to peer messengers if you will, and I can use my own personal journey. I have a 21-year-old with severe autism, my fear was if you get sick can he manage it? He cannot tell me how he feels, cannot tell me what the problem is. What happens if he gets into the hospital? My husband or I would have to go with them? What if we get sick?

These are people who don't know him at all. Can they help to manage it? The answer is no. It would've been a debacle. I think it's hard, I always say if things can't fit on a bumper sticker you have a challenge. This is in a bumper sticker issue. You have to almost explain it as it's not just the autism, it's all that goes with it that becomes a challenge.

This is a difficult population for a lot of reasons, and how do we peel that back and meet people where they are and help them make an informed choice. That's we decided to frame our messaging around, is making an informed choice. Having the information that you need. My son is immunocompromised, I went to his doctor and said I don't want to do the vaccine. He gets an infusion every month and so he gets other people's antibodies. In sunlight, is it in the bag, the IV bag? He's like, no it's not the bag and won't be for a few years.

I said, what do you think about the vaccine? He said Lori we know what to do when he has a flareup but we don't know what to do with COVID. Thousand informed decision to me, versus making a decision outside of that information, as it did cause a flareup for him. His autism was worse because he had a flareup, but we managed it.

That's just my own personal journey with us. That's the messaging that has to come to parents. Helping them think through their journey and how we make informed decisions based on that individual, because I think there's a lot of, I guess mistrust with the medical community for a lot of people.

DR NEECEY HUDSON:

Thank you for sharing that. So many insights there, and you are very right about all of those things. I hope you come to our other ones because we can certainly get into that more in future discussions.

I don't know we have time for another breakout group, as I take you through some of the graphics I will share with you next maybe start thinking about some common themes we've heard. Some different populations might need different considerations in terms of graphics and visuals.

In terms of sort of things that connect either along racial and ethnic lines, or the community that someone belongs to, and start thinking about your target population, what are some of those themes that you could employ in a graphic or in a messaging piece to sort of make that connection with the audience. If you have anything now feel free to drop in the chat.

Like Lori said, if it doesn't fit on a bumper sticker, you know it mean? We very much like to keep things simple. We definitely target our science knowledge to the lay level. We go with a lot of threes as much as possible.-- The law of threes as much as possible.

I wanted to share some of our graphics. In addition to whatever the focus of your piece might be just to complement those with other ancillary pieces that are about making a connection with the audience. Again, for our audiences that typically means people who have felt maligned either healthcare. We certainly are constantly crafting messages to connect on that.

And then in terms of the vaccine we have put together a lot of different messaging for Black communities, Hawaiian communities, Latin communities about different influences that may contribute to their hesitancy, and then again, what we always try to do is bring it back around to the true battle of the species that this is. We tried to focus back on the virus. We personify the virus to link our behavior to the virus being really excited about it. Taking full advantage of our stubbornness and things like that. But again, we like to communicate, we like to understand misgivings etc. but we still need people to understand that while we argue amongst ourselves with our open, uncovered mouths COVID is having a great time at our expense.

DR EMILY HOTEZ:

Can you speak to the last graphic with the police car? I feel that kind of get that a little bit like what we were talking about last time about why it can be so challenging to reach some of these groups we are trying to reach, and kind of what the strategy was for this one.

DR NEECEY HUDSON:

This was one of our earlier graphics. At the beginning we were desperate for people to refocus.

Everyone was talking about experiment a lot, and there's already present-- plenty of mistrust. The pandemic started right around the time of George Floyd's lynching. It was already a crisis.

With those things converging we were hoping to separate peoples very well earned, justifiable mistrust and suspicion from the reality of a global airborne pandemic and what that means to our communities.

That's what I mean about visual tropes. Things that you can communicate very simply with the picture. And then here, this is kind of a different way to engage. This is one of our favorites. The reason why this is so effective is probably because at least for Black communities, a lot of you know the trope of the Black barbecue. You get invited to it, always disputes about who made the potato salad. There's plenty of Goldmine in the black barbecue.

We are trying to play on this potato salad issue because that commentary is really a commentary on hygiene, cleanliness even, or even germ phobia in general. Not trusting that.

If you're like that particular about who made the potato salad surely you need to put your mask back on if germs is not your thing. That's kind of where this came from. I guess that's what I mean. There is several layers of cultural tropes there.

And then this is one that we made for the start of autism awareness month. I put together a lot of great facts and infographics about particular challenge for neurodiversity disabled communities. Like needle phobia and some of the interruption and care of delivery that many groups face. This one obviously has little bit of a different tone which I think you can also strike as well and think, the first ones were little bit more kind of social justice oriented, but I think there's plenty to mind in terms of compassion and empathy as well which we could all use a lot more of I think.

I guess if you have a couple of minutes you can reflect on what you've seen, and think about what I relayed in terms of conceptually why we put these pieces together, and how those same methodologies in a sense, you can use that same thought process to translate that to neurodiverse communities for whatever particular focus you have. Again, not a monolith, you will each have your own considerations to make. They could bout the things, like you said, that draw you in when you first see something, and also if there's particular...

I like to use humor and fear. Sometimes together. There's plenty of different tropes and emotions in subliminal messaging you can utilize to relay your message.

This is a quick exercise maybe for yourself at home, for those of you that joined us next time we will be happy to do a quick show in Tallahassee will you come up with. We hope you do. Try out the law of threes on your own. In Canva try to communicate a simple graphic about one of your favorite hobbies

looking one of these. This one is mine.

If you come back it would be nice if we could do a quick show and tell, and it would be good practice for you to start thinking about ways to conceptualize and convey simple message using words and images.

It's can I send the three things? Not sure what that means. Would you like to speak up, Kelly? We can certainly do that and I will also make the slides available so you can see that. I know we've come to the end. We can stay couple of extra minutes if anyone wants to provide any other input or comments.

DR EMILY HOTEZ:

Lizzie?

SPEAKER:

I'm an occupational therapist in the Houston community and they also have a sister with autism and I work with the nonprofit that Darla spoke about earlier.

I wanted to say thank you so much for providing this. I thought that it had a lot of great things to talk about and think about. I really agree with I guess the perspective of the social norms and really thinking about how you talk to other people and active listening. Just like promoting that sense of trusting and nonjudgment. I just wanted to say thank you.

DR NEECEY HUDSON:

Is there anyone else who has a quick question?

DR EMILY HOTEZ:

Just a quick note if you are hoping to receive CEU from this workshop please make sure that when you filled out the pre-survey that we sent around put your email address so that we have it and have you on record for participation.

I think we are at the end. I will stick around for a couple of minutes if anyone wants to chat or have any additional questions. We hope you will all join us for that May 2 workshop where we continue this conversation.

DR NEECEY HUDSON:

Monahan has a good-- Monica has a good question. We are definitely looking at ways to scale this up on the state-- state and national level. Part of that is looking at different multimedia interventions that we can target like the state and county level with various communities. We are doing some research now on that, analyzing social media and trying to develop a strategy that will reach a large audience.

Any other questions or comments?

Thank you again for joining us. We are excited to be with you this afternoon. Please join us next time, and have a wonderful rest of your week.

DR EMILY HOTEZ:

Goodbye, everyone.

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