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Community Research Fellows Training Hattiesburg, MS Evaluation Report

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Community Research Fellows Training
Hattiesburg, MS
Spring 2016
Evaluation Report

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Report Introduction

The Community Research Fellows Training (CRFT) Hattiesburg program took place between January 12th, 2016 and May 17, 2016. This is the third Mississippi cohort of CRFT and the first Mississippi cohort outside of Jackson, Mississippi. This report reflects the implementation and evaluation of a community based participatory training (CBPR) program for community members in Hattiesburg. The report provides data on the assessment of the program's effectiveness in promoting the role of underserved populations in research by enhancing the capacity for CBPR. In assessing the social network development of the cohort, we seek to understand effectiveness in bridging many community roles to serve the purpose of addressing health disparities. Specifically, the report assesses if the Hattiesburg CRFT program has met its specific aim: To enhance community knowledge and understanding of research.

The following individuals played an instrumental role in the implementation of the program:

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In organizing the Hattiesburg CRFT program, the Community Advisory Board (CAB) offered invaluable input. We would like to thank the following CAB members for their support and contribution of the program:

Kristina Cole, Health Help MS
Maxine Coleman, City of Hattiesburg
Ivie Pulliam, Southeast MS Rural Health Initiative
Annie Jackson, Mississippi Children's Home Services
Julia Brown, Pine Belt Mental Health Resources
Buddy Daughdrill, MS Public Health Association
Samantha Wells, The University of Southern Mississippi
Kathy Yadrick, The University of Southern Mississippi
Danny Patterson, Bayou Clinic

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I. Baseline Assessment

Introduction

The Community Research Fellows Training (CRFT) Program baseline assessment survey was completed by program fellows (n=27) prior to the beginning of the Community Research Training Courses. All baseline assessments were completed prior to January 19, 2016. The purpose of the baseline assessment questionnaire was to evaluate the fellows' understanding of key research concepts to be addressed throughout the training course in weekly modules. Many of the questions were repeated in a post-CRFT assessment after the 16-week training to assess growth. The post assessment results are provided in Section IV of this report.

Demographic Characteristics

As provided in Table 1, the majority of the Hattiesburg CRFT cohort were female (n= 23, 85.2%) and African American (n=17, 74.1%). The remaining fellows reported their race as Caucasian (n=6, 22%) or Asian/Pacific Islander (n=1, 3.7%) and three fellows reported being of two or more races (11%). All but one fellow identified as Non-Hispanic (n=26, 96.3%). Almost all fellows were born in the United States (n=24, 88.9%) with the remaining three fellows' birthplace listed as Germany, Jamaica, and India. Most fellows lived in Hattiesburg, MS (n=19, 70.4%) (see Figure 1), with the other cities of residence listed as Columbia (n=2, 7.4%), Columbus (n=1, 3.7%), D'Iberville (n=1, 3.7%), Gulfport (n=1, 3.7%), Jackson (n=1, 3.7%), Ocean Spring (n=1, 3.7%), and Petal (n=1, 3.7%). Fellows were between 24 and 65 years of age (Mean 40.07 years, SD 11.2 years). Nearly all fellows had attended college (n=26, 96.3%), with approximately 78% receiving a college degree (n=21) and half reporting having completed a graduate degree (n=14, 52%). The fellows' experience with regard to research classes varied,

with about half (n=13, 48%) having never taken a research class prior to their participation in

CRFT. Several respondents reported that they had taken 1-2 research classes (n=6, 22%), several

more that they had taken 3-4 research classes (n=6, 22%), and the remaining fellows reported

that they have taken 5+ research classes (n=2, 7.4%). The majority of the cohort worked full time

(n=18, 66.7%), four fellows (14.8%) worked part time, and 5 fellows (18.5%) were unemployed.

Additionally, 25.9% (n=7) of fellows were students, 11% (n=3) were retired, and 3.7% (n=1)
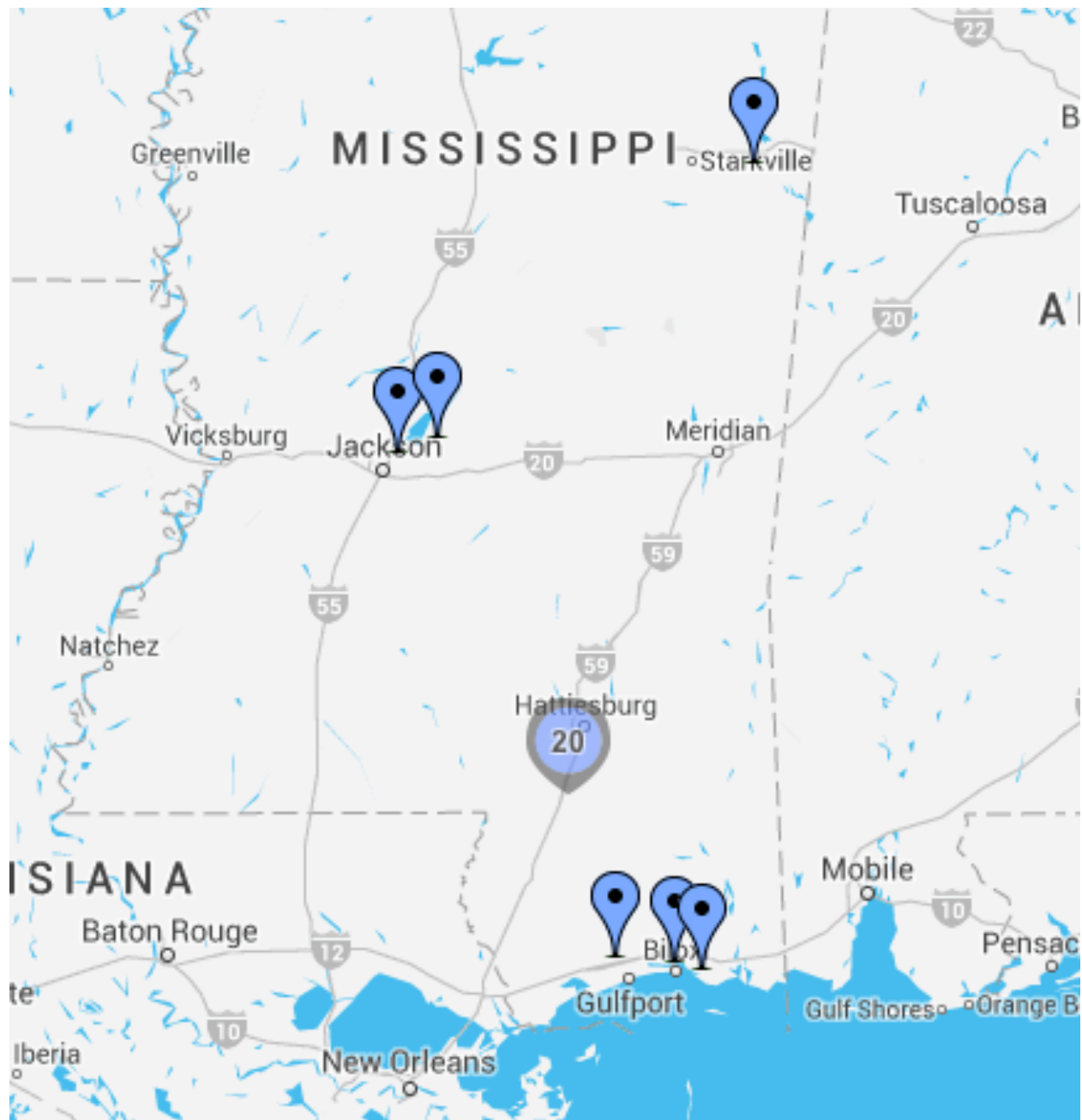
were disabled.

Figure 1: Map of Fellows' Zip Codes

Table 1: Demographic Characteristics of Hattiesburg CRFT Fellows (n=27)

Characteristics	n (%)	N (%)
Gender		
Female	23 (85.2)	**23 (85.2)**
Race		
African American	17 (74.1)	**17 (74.1)**
White	6 (22.0)	**6 (22.0)**
Asian/Pacific Islander	1 (3.7)	**1 (3.7)**
2 or more races	3 (11.0)	**3 (11.0)**
Ethnicity		
Non-Hispanic	26 (96.3)	**26 (96.3)**
Country of Origin		
United States	24 (88.9)	**24 (88.9)**
Germany	1 (3.7)	**1 (3.7)**
India	1 (3.7)	**1 (3.7)**
Jamaica	1 (3.7)	**1 (3.7)**
City of Residence in Mississippi		
Hattiesburg	19 (70.4)	**19 (70.4)**
Columbia	2 (7.4)	**2 (7.4)**
Columbus	1 (3.7)	**1 (3.7)**
D'Iberville	1 (3.7)	**1 (3.7)**
Gulfport	1 (3.7)	**1 (3.7)**
Jackson	1 (3.7)	**1 (3.7)**
Ocean Springs	1 (3.7)	**1 (3.7)**
Petal	1 (3.7)	**1 (3.7)**
Highest level of Education		
Some college or Associates Degree	5 (18.5)	**5 (18.5)**
College degree	7 (26.0)	**7 (26.0)**
Graduate degree	14 (52.0)	**14 (52.0)**
Number of Research Classes Completed		
5 or more	2 (7.4)	**2 (7.4)**
3-4	6 (22.0)	**6 (22.0)**
1-2	6 (22.0)	**6 (22.0)**
None	13 (48.0)	**13 (48.0)**
Current Employment Status		
Full time	18 (66.7)	**18 (66.7)**
Part time	4 (14.8)	**4 (14.8)**
Unemployed	3 (11.0)	**3 (11.0)**

Fellows were asked to define key terms and concepts that were considered essential components to understanding the Hattiesburg CRFT learning objectives (see syllabus from the Mississippi State Department of Health Office of Health Disparities in Appendix A). The data were coded without reference to any identifiers to the respondent. The frequencies of the coded responses are provided in Table 1[2].

Table 2: Knowledge of Key Terms and Concepts (n=27)[3]

Question	0: I don't know n (%)	1: Incorrect Answer n (%)	2: Somewhat familiar n (%)	3: Demonstrates Clear Understanding n (%)	No Response n (%)
What is informed consent?	3 (11.0)	1 (3.7)	6 (22.0)	15 (55.6)	2 (7.4)
What is the Belmont Report?	17 (63.0)	1 (3.7)	4 (14.8)	3 (11.0)	2 (7.4)
What is the Tuskegee experiment?	3 (11.0)	1 (3.7)	9 (33.0)	11 (40.7)	2 (7.4)
Define Health Literacy.	7 (25.9)	2 (7.4)	3 (11.0)	13 (48.0)	2 (7.4)
Define evidence based public health.	9 (33.0)	1 (3.7)	4 (14.8)	11 (40.7)	2 (7.4)
Define cultural competency.	8 (29.6)	3 (11.0)	2 (7.4)	12 (44.4)	2 (7.4)
What role does the IRB play in research?	8 (29.6)	0	3 (11.0)	14 (51.9)	2 (7.4)
What is HIPAA?	4 (14.8)	0	6 (22.0)	15 (55.6)	2 (7.4)
Explain the difference between qualitative and quantitative research methods.	8 (29.6)	1 (3.7)	1 (3.7)	15 (55.6)	2 (7.4)
What is the difference between primary and secondary data?	11 (40.7)	4 (14.8)	1 (3.7)	9 (33.0)	2 (7.4)

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[2] All fellows completed the baseline assessment to completion, but not every fellow answered all questions. Every question (excluding the demographics section) had 2-4 missing responses. Therefore, most questions will not add up to 100% as two or more fellows did not provide an answer.
    [3] Responses were coded as 0, 1, 2, or 3. When the respondent reported that they did not know the answer and did not provide an answer, it was coded as "0." When the respondent provided an answer, but it was incorrect, it was coded as "1." When the respondent provided an answer that contained two or three key words and the response indicated that the respondent was somewhat familiar with the concept or definition, it was coded as "2." Finally, when the response demonstrated a clear understanding of the concept or definition, it was coded as "3."

Explain the difference between Community Based Participatory Research and Traditional Research.	11 (40.7)	1 (3.7)	4 (14.8)	9 (33.0)	2 (7.4)
What is epidemiology?	10 (37.0)	1 (3.7)	4 (14.8)	9 (33.0)	3 (11.0)
What is a clinical trial?	9 (33.0)	3 (11.0)	6 (22.0)	7 (25.9)	2 (7.4)
What is the mixed methods approach?	17 (63.0)	0	4 (14.8)	4 (14.8)	2 (7.4)
What is photovoice?	22 (81.5)	0	2 (7.4)	1 (3.7)	2 (7.4)
What is the purpose of a focus group?	10 (37.0)	0	4 (14.8)	11 (40.7)	2 (7.4)
What is a family health history?	3 (11.0)	1 (3.7)	0	21 (77.8)	2 (7.4)
What type of information should you expect to get from a community health assessment?	7 (25.9)	0	7 (25.9)	11 (40.7)	2 (7.4)
Describe the health promotion planning model that you believe is best to prevent and reduce substance abuse in an African American community?	16 (59.3)	0	0	9 (33.0)	2 (7.4)
What are the social determinants of health?	13 (48.0)	1 (3.7)	4 (14.8)	6 (22.0)	3 (11.0)
List three social determinants of health?	11 (40.7)	1 (3.7)	2 (7.4)	11 (40.7)	2 (7.4)
What is research?	5 (18.5)	0	3 (11.0)	17 (63.0)	2 (7.4)
Define racial health disparities.	9 (33.0)	1 (3.7)	2 (7.4)	12 (44.0)	3 (11.0)
What are the components of a SMART goal?	15 (55.6)	1 (3.7)	0	9 (33.0)	2 (7.4)
What is the Odds Ratio?	19 (70.0)	0	0	4 (14.8)	4 (14.8)
What is a p value?	13 (48.0)	1 (3.7)	2 (7.4)	9 (33.0)	2 (7.4)
List an effective method to advocate for a specific health issue in your community.	16 (59.3)	1 (3.7)	0	7 (26.0)	3 (11.0)
How is research used to develop health policy?	11 (40.7)	0	1 (3.7)	13 (48.0)	2 (7.4)

Fellows were also asked to rate their agreement with twelve statements regarding perceptions of research (Table 3), their level of agreement with statements related to the role of the community (Table 4), and how involved the community should be in the research process (Table 5). Fellows were then asked questions designed to gain insight into their knowledge of genetics in health (Table 6). Finally, Table 7 provides the frequency of responses regarding the need for assistance with completing medical forms.

Table 3: Perceptions of Research (n=27)

Question	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No Response	Mean
a. **To get people to take part in a study, medical researchers usually do not explain all the dangers about participation.**	6 (22.0)	4 (14.8)	6 (22.0)	8 (29.6)	1 (3.7)	2 (7.4)	2.8
b. **Participants should be concerned about being deceived or misled by medical researchers.**	3 (11.0)	5 (18.5)	6 (22.0)	7 (25.9)	4 (14.8)	2 (7.4)	3.2
c. **Usually, researchers who make mistakes try to cover them up.**	2 (7.4)	7 (25.9)	12 (44.0)	3 (11.0)	1 (3.7)	2 (7.4)	2.8
d. **Medical researchers act differently toward minority participants than white participants.**	3 (11.0)	5 (18.5)	8 (29.6)	5 (18.5)	3 (11.0)	3 (11.0)	2.9
e. **Medical researchers unfairly select minorities for their most dangerous studies.**	5 (18.5)	6 (22.0)	6 (22.0)	7 (25.9)	1 (3.7)	1 (3.7)	2.7
f. **Some medical research projects are covertly designed to expose minority group diseases like AIDS.**	7 (25.9)	7 (25.9)	9 (33.0)	1 (3.7)	0	3 (11.0)	2.1
g. **Medial researchers are generally honest in telling participants about different treatment options available for their conditions.**	0	3 (11.0)	11 (40.7)	9 (33.0)	2 (7.4)	2 (7.4)	3.4
h. **Usually, medical researchers tell participants everything about possible dangers.**	1 (3.7)	5 (18.5)	10 (37.0)	7 (25.9)	2 (7.4)	2 (7.4)	3.2
i. **All in all, medical researchers would not conduct experiments on people without their knowledge.**	1 (3.7)	3 (11.0)	5 (18.5)	10 (37.0)	6 (22.0)	2 (7.4)	3.7
j. **Most medical researchers**	0	5 (18.5)	7 (25.9)	9	4 (14.8)	2 (7.4)	3.5

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No Response	Mean
would not lie to people to try and convince them to participate in a research study. 2 (7.4)				(33.0)			
k. In general, medical researchers care more about doing their research than about the participants' medical needs.	1 (3.7)	12 (44.0)	5 (18.5)	6 (22.0)	1 (3.7)	2 (7.4)	2.8
l. Researchers are more interested in helping their careers than in learning about health and disease.	5 (18.5)	8 (29.6)	10 (37.0)	2 (7.4)	0	2 (7.4)	2.4

Table 4: Community Influence (n=27)

Question	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No Response	Mean
a. By working together, people in my community can influence decisions that affect the community.	0	0	1 (3.7)	8 (29.6)	16 (59.0)	2 (7.4)	4.6
b. People in my community work together to influence decisions at a local, state, or national level that affect the community.	1 (3.7)	4 (14.8)	9 (33.0)	3 (11.0)	8 (29.6)	2 (7.4)	3.5
c. I am satisfied with the amount of influence that I have on decisions that affect my community.	4 (14.8)	8 (29.6)	6 (22.0)	3 (11.0)	4 (14.8)	2 (7.4)	2.8

Table 5: Perception of Community's Role in Research (n=27)

Question	Not at all involved (0)	A little bit involved (1)	Somewhat involved (2)	Quite a bit involved (3)	Extremely involved (4)	No Response	Mean
a. Defining the problem.	3.7%	3.7%	3.7%	25.9%	51.8%	11.0%	3.0
b. Deciding on issues of research.	3.7%	3.7%	18.5%	25.9%	37.0%	11.0%	2.7
c. Developing research questions.	3.7%	7.4%	29.6%	25.9%	25.9%	7.4%	2.5
d. Designing interviews and/or survey questions.	14.8%	14.8%	11.0%	29.6%	22.0%	7.4%	2.1
e. Collecting data.	11.0%	14.8%	14.8%	14.8%	37.0%	7.4%	2.4
f. Recruiting study participants.	11.0%	7.4%	11.0%	18.5%	44.0%	7.4%	2.6
g. Analyzing collected data.	25.9%	14.8%	25.9%	3.7%	22.0%	7.4%	1.6

h. Disseminating and sharing findings.	14.8%	3.7%	14.8%	14.8%	44.0%	7.4%	2.6
i. Grant proposal writing.	18.5%	11.0%	14.8%	29.6%	18.5%	7.4%	2.0
j. Choosing research methods.	25.9%	11.0%	14.8%	18.5%	18.5%	11.0%	1.7
k. Developing sampling procedures.	29.6%	3.7%	18.5%	18.5%	18.5%	11.0%	1.7
l. Implementing the intervention.	11.0%	7.4%	11.0%	18.5%	40.7%	11.0%	2.5
m. Collecting primary data.	11.0%	11.0%	3.7%	33.0%	29.6%	11.0%	2.4
n. Interpreting study findings.	25.9%	0	37.0%	11.0%	18.5%	7.4%	1.8
o. Writing reports and journal articles.	29.6%	3.7%	29.6%	11.0%	18.5%	7.4%	1.7
p. Giving presentations at meetings and conferences.	18.5%	3.7%	25.9%	22.0%	22.0%	7.4%	2.1

Table 6: Knowledge of Genetic Health

Question	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No Response	Mean
a. I know how to assess the role of genes for health.	29.6%	22.0%	22.0%	14.8%	0	11.0%	1.1
b. I know how to assess my genetic risk for disease.	22.0%	18.5%	18.5%	29.6%	3.7%	7.4%	2.5
c. I can explain genetic issues to people.	22.0%	7.4%	33.0%	29.6%	0	7.4%	2.6

Table 7: Frequency of Need for Assistance with Medical Documents (n=27)

Question	Always (4)	Often (3)	Sometimes (2)	Rarely (1)	Never (0)	No Response	Mean
a. How often do you have someone like a family member, friend, hospital/clinic worker, or caregiver help you read hospital materials?	0	0	11.0%	18.5%	59.0%	11.0%	0.4
b. How often do you have problems learning about your medical condition because of difficulty understanding written information?	0	0	7.4%	29.6%	55.6%	7.4%	0.4

Health Information

Fellows were then asked frequently they found health information through various sources, such as magazines and newspapers, television, and the Internet (Table 8). Fellows were also asked to rate how frequently they talked to friends and family members about health. Some fellows indicated that they "Always" talked to friends and family members about health (n=6, 22.0%), but the majority of fellows (n=15, 55.6%) reported "Often." Additionally, two fellows (7.4%) reported "Sometimes," and two reported "Rare" (7.4%). Two fellows did not provide a response (7.4%).

Table 8: Frequency of Sources for Health Information (n=27)

Question	Everyday (6)	Several days per week (5)	2-3 times per month (4)	About once per month (3)	5-10 times per year (2)	Less than 5 times per year (1)	Not in the last year (0)	No Response	Mean
a. Some newspapers or general magazines publish a special section that focuses on health. In the past 12 months, about how often have you read such health sections?	3.7%	3.7%	18.5%	25.9%	11.0%	18.5%	11.0%	7.4%	2.3
b. Some local television news programs include special segments of their newscast that focus on health issues. In the past 12 months, how often have you watched health segments on local news?	7.4%	14.8%	18.5%	18.5%	0	18.5%	14.8%	7.4%	2.7
c. Some people notice information about health on the internet, even when they are not trying to find out about a health concern they have or someone in the family has. About how often have you read this sort of health information in the	7.4%	7.4%	33.0%	18.5%	14.8%	7.4%	3.7%	7.4%	3.1

past 12 months?									
d. In the past thirty days, how often would you say that you have looked for information about ways to stay healthy or to feel better?	11.0%	33.0%	29.6%	18.5%	-[4]	-	-	7.4%	4.1

Calculation Skills Self-Assessment

Finally, fellows rated their ease of number use. The mean and standard deviations for

these statements are provided in Table 9.

Table 9: Ease of Number Usage (n=27)

Answer	Scale 0-6	Average value	Standard Deviation
a. How good are you at working fractions?	Not at all good—Extremely good	3.04	1.93
b. How good are you at working percentages?	Not at all good—Extremely good	3.2	2.08
c. How good are you at calculating a 15% tip?	Not at all good—Extremely good	4.08	1.99
d. How good are you at figuring out how much a shirt will cost if it is 25% off?	Not at all good—Extremely good	4.12	1.94
e. When reading the newspaper, how helpful are tables and graphs that are part of a story?	Not at at helpful—Extremely helpful	4.04	1.84
f. When people tell you that there is a chance of something happening, do you prefer they use words (e.g. it rarely happens) or numbers (e.g. there's a 1% chance)?	Always prefer words—Always prefer numbers	3.5	2.09
g. When you hear the weather forecast, do you prefer predictions using percentages (e.g. there is a 20% chance of rain today) or predictions using words only (e.g. there is a small chance or rain today)?	Always prefer percentages—Always prefer words	2.16	2.27
h. How often do you find numerical information to be useful?	Never—Very often	4.32	1.52

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[4] For the last question (In the past 30 days, how often would you say that you have looked for information about ways to stay healthy or to feel better?), three of the question options were not provided since the responses were not applicable due to the time frame asked in the question (30 days).

II. Baseline Social Network Analysis

The CRFT Social Network Analysis Survey was also conducted with the Hattiesburg CRFT fellows prior to the first meeting of the cohort. This was important for ensuring that that network connections reflected in the baseline social network data were not influenced by the CRFT program. The social network survey was be repeated at the end of the program to assess: 1) the network that has formed as a result of the program and 2) how empowered individuals feel to improve the health of their community. This section presents the baseline data and Section V, Final Social Network Analysis, will provide the results for the end of the course and assess the two aforementioned objectives.

CRFT fellows were asked about their potential contributions to improving community health. When asked to check all that apply, the majority of fellows (>50%) feel they can contribute through community connections (70.4%), connections to communities experiencing health disparities (55.6%), and leadership (85.2%). When asked to indicate their single most important contribution, "connections to communities that are experiencing health disparities" was the most selected (25.9%). These responses indicate that fellows recognize the importance of social networks, both between those seeking to improve communities and these individuals' connections to the communities they seek to improve.

The fellows were provided with a list of potential CRFT outcomes and asked to indicate all outcomes that they consider critical to improving community health. All items were selected by a majority of fellows, with increased knowledge sharing (81.5%), public awareness (88.9%), and increased access to services (92.6%) being most selected. When asked to select the main reason they participate in CRFT, creating healthier environments (22.2%) was the dominant answer.

Table 10: Contribution to Improving Community Health (n=27)

Response:	Please indicate what you can potentially contribute to improving community health. (Choose all that apply).	What is your single most important contribution to improving community health? (Select one).
Data resources, including data sets, collection and analysis	8 (29.6%)	3 (11.1%)
Providing objectives to my organization	12 (44.4%)	2 (7.4%)
Specific health expertise	10 (37.0%)	1 (3.7%)
Expertise other than in health	9 (33.3%)	2 (7.4%)
Community connections	19 (70.4%)	3 (11.1%)
Connection to communities that are experiencing health disparities	15 (55.6%)	7 (25.9%)
Facilitation	9 (33.3%)	5 (18.5%)
Leadership	23 (85.2%)	0 (0%)
Broad activity for community health priorities	12 (44.4%)	1 (3.7%)
Other (please specify)	3 (11.1%)	3 (11.1%)

Table 11: Reasons for Participating in CRFT (n=27)

Response:	Which of the following CRFT results are critical to community health improvement? (Choose all that apply.)	Which of the following is the main reason you participate in CRFT? (Select one.)
Improving resource sharing	20 (74.0%)	1 (3.7%)
Increased knowledge sharing	22 (81.5%)	3 (11.1%)
Coordinated communication	18 (66.7%)	0 (0%)
Networking with individuals that do similar things	20 (74.0%)	0 (0%)
Networking with individuals that do different things	18 (66.7%)	2 (7.4%)
Data and information available through the program	19 (70.4%)	2 (7.4%)
Coordinated health assessment	17 (63.0%)	0 (0%)
Increased access to services	25 (92.6%)	0 (0%)
Improved health outcomes	17 (63.0%)	5 (18.5%)
Reduction of health disparities	21 (77.8%)	3 (11.1%)
Public awareness	24 (88.9%)	3 (11.1%)
Creating healthier environments (e.g., schools, worksites, community)	20 (74.0%)	6 (22.2%)
Policy, law, and/or regulation	17 (63.0%)	2 (7.4%)

Fellows indicated that, to date, they have on average only been somewhat successful (48.1%) in improving community health. However, in the next year, they feel on average that they will be very successful (48.1%) in impacting the health of their community. When asked which aspect of CRFT the fellows believe will help them achieve these goals, all items were selected by a majority of fellows (>50%), with having a shared vision and goals (77.8%), exchanging information and knowledge (77.8%), research skills (81.5%), and grant writing skills (88.9%) emerged as the most important skills for making an impact in community health.

Table 12: Success in Community Health Impact (n=27)

Response:	To date, how successful have you been at impacting health in the community?	In the next year, how successful do you feel you will be at impacting health in the community?
Very Successful	3 (11.1%)	13 (48.1%)
Successful	4 (14.8%)	8 (29.6%)
Somewhat Successful	13 (48.1%)	2 (7.4%)
Not sure	4 (14.8%)	4 (14.8%)
Not Successful	3 (11.1%)	0 (0%)

Table 13: CRFT Skills for Improving Community Health (n=26)

| Response:	What aspects of CRFT do you think will help you achieve these goals? (Choose all that apply)
Brining together diverse individuals	20 (74.0%)
Meeting regularly	14 (51.8%)
Exchanging information/knowledge	21 (77.8%)
Informal relationships created	19 (70.4%)
Grant writing skills	24 (88.9%)
Research skills	22 (81.5%)
Having a shared vision and goals	21 (77.8%)
Collective synergy	15 (55.6%)

Prior to the beginning of CRFT, the network cohesion metrics reflect macro-characteristics of the CRFT network as one that is quite unconnected network (see Table 14 and Figure 1). All but one individual are connected to the network. That means that 25 of the 26

fellows either knew another fellow or were known by another fellow prior to CRFT. The data

provides that the average fellow is connected 2.1 other fellows. Only 8.1% of the possible

connections among fellows exist which indicates that there is a low overall level of connection in

the network. The diameter of the network (the largest geodesic distance within the connected

network) is six. This indicates that no fellows are more than six steps away from another fellow

in the connected network (which excludes the one fellow who is not connected). The average

distance of the baseline CRFT network is 2.5, meaning on average it would take fellows 2.5

steps to reach all other fellows. These measures will provide meaning to the ability of the

program to foster collaboration when they are re-assessed at the end of the program.

Table 14: Social Network Measures of Cohesion (n=26)

Network Measure	Statistic
Average Degree	2.111
H-Index	3
Density	0.081
Components	17
Component Ratio	0.615
Connectedness	0.315
Fragmentation	0.685
Closure	0.253
Average Distance	2.498
SD Distance	1.279
Diameter	6
Breadth	0.832
Compactness	0.168
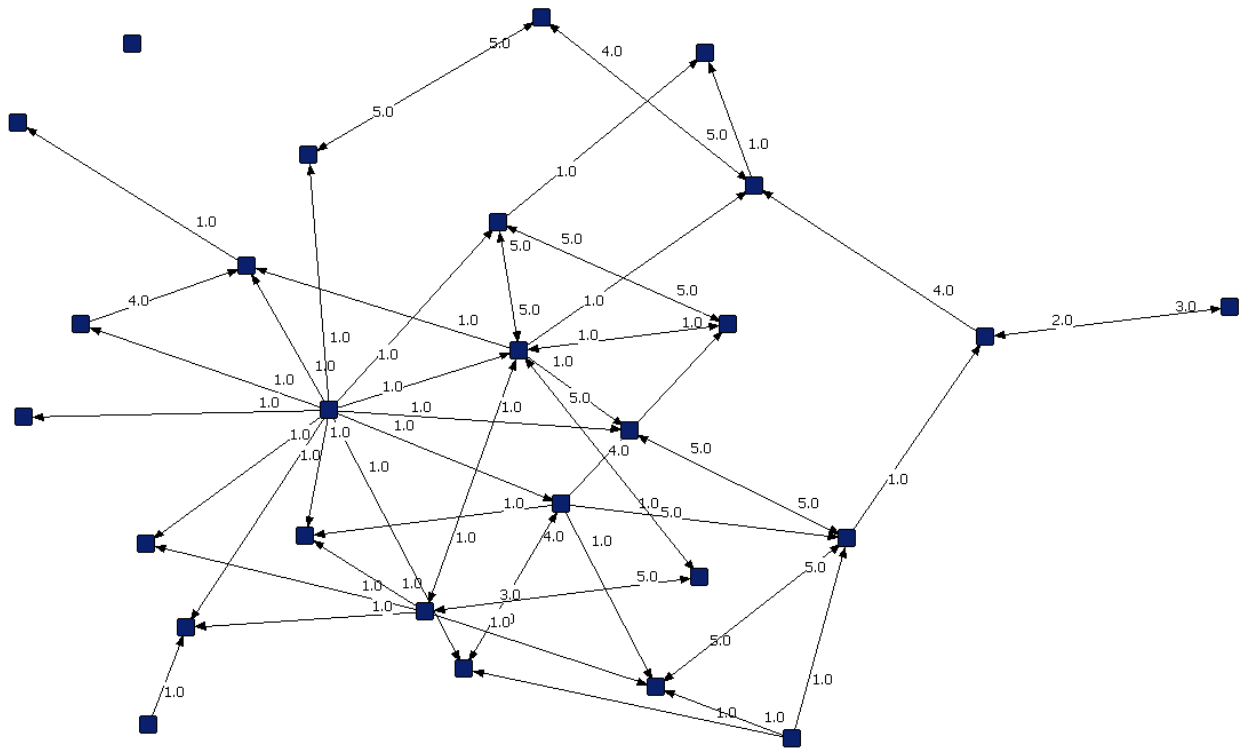
III. Mid-Term Assessment

Introduction

The MSDH CRFT mid-training assessment survey was completed by the Hattiesburg fellows (n=23) between weeks 8 and 9 of the 16-week course. The mid-training assessment solicited the Hattiesburg fellows' evaluations of the first half of the program and improvements they could suggest for the second half of the program. This section provides the results of the assessment, which have been coded for analysis.

Importance of Training So Far

Fellows were asked to list the three most important things they had learned so far in the program and their responses were coded to at least one of fifteen themes identified from within the data. Health Disparities (n=14) was the most frequently coded category among them, followed by Community Engagement (n=9), Research Methods (n=8), Evidence Based Research (n=7), and Cultural Competency and Community Research/Surveys (n=5 each)(see Table 15).

Table 15: Midterm- Important Things Learned

Q3: What are the three most important things you have learned during this training so far?	First Response	Second Response	Third Response	Total
Health Disparities	5	3	6	14
Community Engagement/Communication	3	2	4	9
Research Methods	3	2	3	8
Evidence Based Research	3	2	2	7
Cultural Competency	2	2	1	5
Community Research/Surveys	2	3	0	5
Epidemiology	1	0	3	4

Health Literacy	1	2	1	4
Local Resources	1	0	2	3
Networking	0	2	0	2
Family History	1	1	0	2
CHW	0	2	0	2
Effective Planning	1	0	0	1
Self-care/Self-Management	0	1	0	1
Presenters	0	0	1	1

Table 16: Topics Not Covered

Q4: Are there things/topics you would like to learn about but have not been covered?	Total (%)
None	7 (30%)
Grant Writing	2 (8%)
Research Methodology	2 (8%)
Mental Health	2 (8%)
Community Health Advocacy	2 (8%)
Formulation of Research Projects	2 (8%)
Communication	1 (4%)
Health Policy Research	1 (4%)
Resources	1 (4%)
Interviewing Skills	1 (4%)
Networking	1 (4%)
Lobbying	1 (4%)

Strengths and Weaknesses

Fellows were asked to list what they considered the three greatest strengths of the CRFT program based on their experience in the first half. The most frequently mentioned strength was the CRFT Presenters (n=12), followed by Information/Topics (n=11). The rest of these results can be found in Table 17.

Table 17: Greatest Strengths of Program

Q5: What are the three greatest strengths of this training?	First Response	Second Response	Third Response	Total
Presenters	6	4	2	12
Information/Topics	6	4	1	11
Instructors/Fellowship	1	0	5	6
Diverse Staff/Class	2	4	0	6
Material/Resources	0	4	2	6
Community Health and Demographics	2	1	2	5
Schedule/Organization	0	1	4	5
Networking	0	1	3	4
Research	1	2	0	3
Case Studies	1	0	1	2
Homework	1	1	0	2
Planning	1	0	0	1
Learning Environment	1	0	1	2
Community Empowerment	0	0	2	2
Communication	1	0	0	1
Interactive Class	0	1	0	1

The fellows also reported the three greatest weaknesses of the program based on their

experience in the first half. Most fellows, however, did not think the program, to date, had

weaknesses (n=18). Of the remaining respondents, the most frequent weakness mentioned,

however, was the length or time of the program (n=6). Three fellows wrote that the program was

too short or that there was not enough time provided. The other three responses gave no

indication as to whether they felt the length/time of the program was too short or too long. The

second weakness was the topics covered and/or presentations. Lack of diversity in the topics and

presentations was mentioned specifically. The third most frequently mentioned response was

lack of discipline and excessive talking (n=5; see Table 18).

Table 18: Weaknesses of the Program

Q6: What are the three greatest weaknesses of this training?	First Response	Second Response	Third Response	Total
None	4	7	7	18
Length/time of training	2	3	1	6
Topics and Presentations/Presenters	2	2	1	5
Lack of discipline and excessive talking	2	2	1	5
No follow-up training	3	1	0	4
Application of method	1	0	3	4
Location	0	0	3	3
Homework	1	1	0	2
Pretest	1	0	0	1
More hands on activities	1	0	0	1
Size of class	1	0	0	1
Participants' interest not taken into account	1	0	0	1
Movement between group exercises	1	0	0	1
No recaps	0	1	0	1

Presentation Styles

Fellows were also asked about which presentation style they find most effective. Respondents were prompted to select (as many as apply, including all or none) of the following presentation styles used in the program: Case studies, role-play, lectures, quizzes, and group exercises. The two more frequent answers were case studies and lectures (n=8, each). Seven fellows mentioned group exercises and six fellows cited "All of the above" (see Table 19).

Table 19: Most Effective Presentation Styles

Q7: What presentation styles have been more effective for you? (Examples: case studies, role play, lecture, quiz, group exercises)	Total
Case studies	8
Lectures	8
Group exercises	7
All of the above	6
Role play	3
Quizzes	1

Further Evaluation

Respondents were asked to rate their level of agreement with the following four statement: 1) The CRFT staff is knowledgeable and helpful; 2) I would recommend the CRFT program to others; 3) None of the information presented is new to me; 4) CRFT has provided me with networking opportunities in my community. These statements were rated on a scale from strongly disagree (1) to strongly agree (5). The majority of respondents agreed with all but one of the statements. Approximately 74% disagreed/strongly disagreed with the statement "None of the information presented is new to me." Further information about this question can be found in Figure 2 and Table 20.
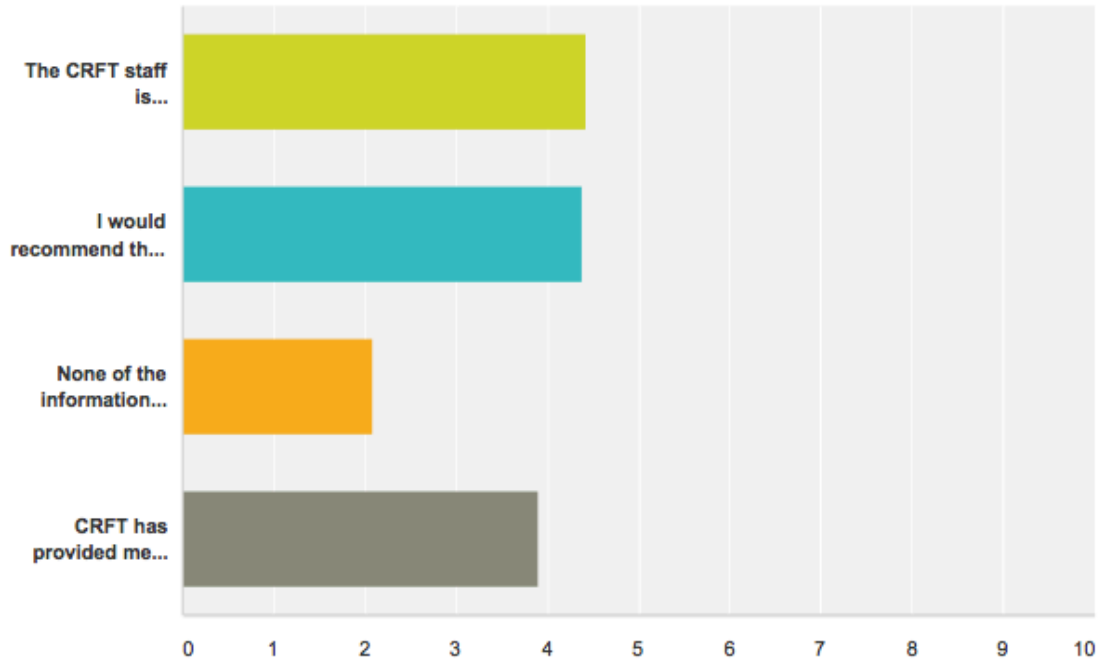
Figure 2: Agreement on Evaluation Statements

Table 20: Frequency of Agreement with Evaluation Statements

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total	Weighted Average
The CRFT staff is knowledgeable and helpful	4.35% 1	0.00% 0	0.00% 0	39.13% 9	56.52% 13	23	4.43
I would recommend the CRFT program to others	4.35% 1	0.00% 0	4.35% 1	34.78% 8	56.52% 13	23	4.39
None of the information presented is new to me	17.39% 4	56.52% 13	26.09% 6	0.00% 0	0.00% 0	23	2.09
CRFT has provided me with networking opportunities in my community	4.35% 1	4.35% 1	30.43% 7	17.39% 4	43.48% 10	23	3.91

Additional Comments on Training Sessions

Next, respondents were asked to provide additional comments or suggestions, if any, that they have about the training sessions. "None" was indicated by eleven respondents. However, comments were provided about the need for more technical support, program extensions, more group participation, networking, and more information on mental health (see Table 21).

Table 21: Additional Suggestions/Comments about Training Sessions

Q9: Please provide additional comments/suggestions for training sessions. If you don't have any comments, please type "none" in the blank provided.	Total
None	11
Technical Support	1
Programs extended	1
Participation/in-put of group	1
Networking	1
Mental Health	1

Role of Fellows

Fellows were asked to report their current role in the community. Twenty-nine percent reported being Academics, 29% work for Community Based Organizations, and 12% have a role in Government. Further information about this question can be found in Figure 3 and Table 22.

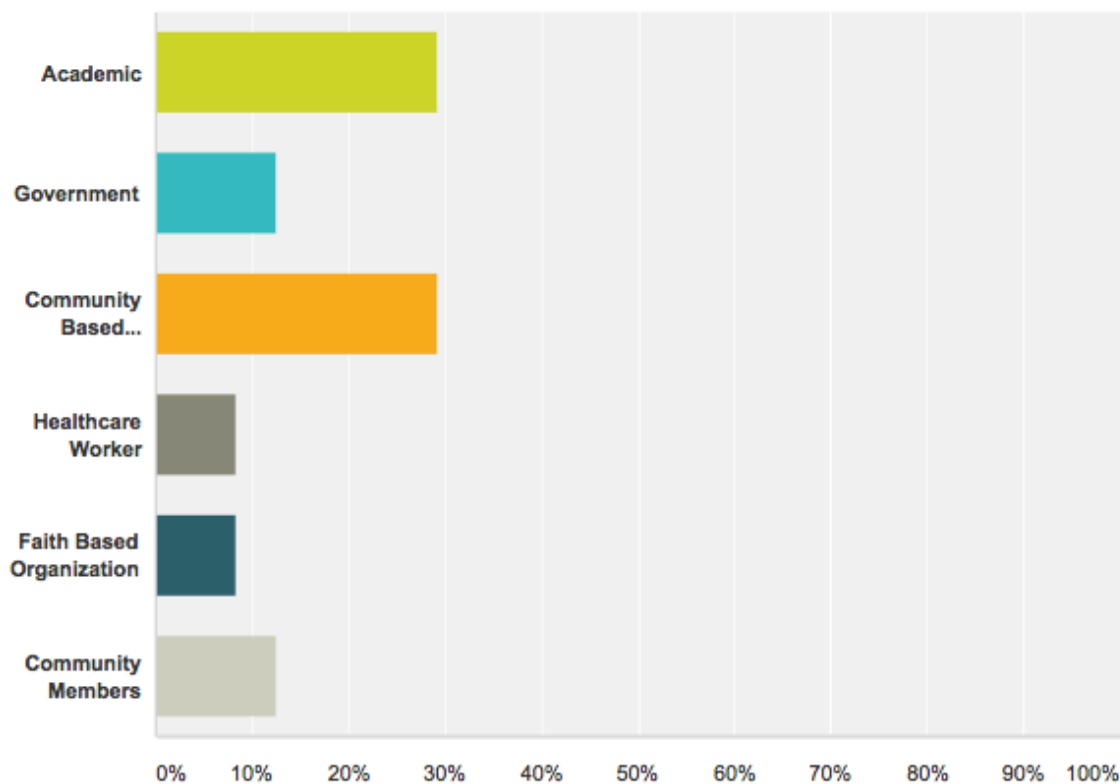**Figure 3: Fellows' Current Roles in the Community**

Table 22: Total Percentages of Each Fellow's Role

Answer Choices	Responses	
Academic	29.17%	7
Government	12.50%	3
Community Based Organization	29.17%	7
Healthcare Worker	8.33%	2
Faith Based Organization	8.33%	2
Community Members	12.50%	3
Total		24

Impact from Training

To measure the impact of the training so far, fellows were asked to provide one example of how the training has improved their daily practice and/or community work. Community Development was selected by the most respondents (n=12), which included responses regarding better strategies to address community members and the issues communities face. The proper ways to conduct surveys was also a response mentioned twice, as was proper ways to network (see Table 23).

Table 23: How Training has Improved Daily Practice/ Community Work

Q11: Please provide one example of how this training has improved your daily practice and/or community work (if any).	Total
Community Development	12
Surveys	2
Networking	2
Cultural Competency	1
Teaching Techniques	1
Health Disparities	1
Family History	1
Epidemiology	1
Mississippi Development	1

Fellows were also asked if they have done anything differently as a result of the CRFT training. The most frequent response was improved research methods skills (n=5), as well as

more knowledge when it comes to community development (n=5). The third most frequent

response, however, was "None" (n=3) (see Table 24).

Table 24: Impact of CRFT Training

Q12: What things have you done differently as a result of the CRFT training?	Total
Research Methods	5
Community Development	5
None	3
Health	2
Networking	1
Communication	1
Literature	1
Health Disparities	1
Understanding Bias	1
Understanding Aims and Objectives	1
Hosting Techniques	1

Additional Training Materials

Finally, fellows were asked if there were any additional training materials they would like

to receive to enhance their learning experience to which nine respondents reported "none," three

reported that they would like information on how to pursue further certification, three

respondents also mentioned that they would like more information about the presentations, and

three more would like more information concerning how to effectively plan programs (see Table

25).

Table 25. Additional Training Materials to Enhance Fellows' Learning Experience

Q13: Are there additional training materials you would like to receive to enhance your learning experience?	Total
None	9
Information on further certification	3
Presentations/Presenters	3
Information on Planning Programs	3
Information on more Health Topics and Disparities	2
Reinforcement	1
Updated Dropbox	1
Information on Grant Writing	1

IV. Final Assessment

Introduction

The MSDH CRFT final assessment survey was completed by community research fellows (n=19) after the final class of the Community Research Training course. All final assessments were completed between May 17, 2016 and May 27, 2016. The final assessment questionnaire paralleled the preliminary assessment for the purpose of evaluating Hattiesburg CRFT fellows' understanding of key research concepts that were assessed throughout the training course in weekly modules.

Defining Key Terms and Concepts

The first section of the survey assessed key terms and concepts that were considered essential components to understanding research items and were covered during the training courses. Fellows were first asked to define the key terms. The answers were coded without reference to the identity of respondent. Frequencies of the codes for each section are provided in Table 26. Table 27 provides the frequencies for responses regarding the fellow's level of knowledge regarding the role of genetics in health.

Table 26: Evaluation of fellows' knowledge of key terms and concepts (n=19)

Question	0: I don't know n (%)	1: Incorrect Answer n(%)	2: Somewhat familiar n(%)	3: Demonstrates Clear Understanding n(%)
What is Informed Consent?	1 (5%)	1 (5%)	11 (58%)	6 (32%)
What is the Belmont Report?	0 (0%)	2 (10%)	3 (16%)	14 (74%)
What is the Tuskegee experiment?	0 (0%)	0 (0%)	7 (37%)	12 (63%)
Define Health Literacy.	0 (0%)	1 (5%)	9 (47%)	9 (47%)
Define evidence-based public health.	1 (5%)	2 (10%)	8 (42%)	8 (42%)
Define Cultural Competency.	0 (0%)	1 (5%)	8 (42%)	10 (53%)
What role does the IRB play in research?	0 (0%)	1 (5%)	7 (37%)	11 (58%)
What is HIPPA?	0 (0%)	1 (5%)	11 (58%)	7 (37%)
Explain the difference between qualitative and quantitative research methods.	1 (5%)	0 (0%)	7 (37%)	11 (58%)
What is the difference between primary and secondary data?	2 (10%)	3 (16%)	6 (32%)	8 (42%)
Explain the difference between Community Based Participatory Research and Traditional Research.	1 (5%)	2 (10%)	7 (37%)	9 (47%)
What is epidemiology?	0 (0%)	3 (16%)	5 (26%)	11 (58%)
What is a clinical trial?	0 (0%)	2 (10%)	7 (37%)	10 (53%)
What is the mixed methods approach?	0 (0%)	4 (21%)	6 (32%)	9 (47%)
What is photovoice?	0 (0%)	0 (0%)	3 (16%)	16 (84%)
What is the purpose of a focus group?	1 (5%)	1 (5%)	8 (42%)	9 (47%)
What is a family health history?	0 (0%)	3 (16%)	7 (37%)	3 (47%)
What type of information should you expect to get from a community health assessment?	0 (0%)	4 (21%)	9 (47%)	6 (32%)
Describe the health promotion planning model that you believe is best to prevent and reduce substance abuse in an African American community?	9 (47%)	0 (0%)	3 (16%)	7 (37%)

What are the social determinants of health?	0 (0%)	2 (10%)	5 (26%)	12 (63%)
List three social determinants of health.	0 (0%)	0 (0%)	0 (0%)	19 (100%)
What is research?	0 (0%)	0 (0%)	6 (32%)	13 (68%)
Define racial health disparities.	1 (5%)	3 (16%)	11 (58%)	4 (21%)
What are the components of a SMART goal?	0 (0%)	2 (10%)	3 (16%)	12 (63%)
What is the Odds Ratio?	2 (10%)	4 (21%)	2 (10%)	11 (58%)
What is a p value?	3 (16%)	6 (32%)	3 (16%)	7 (37%)
List an effective method to advocate for a specific health issue in your community.	3 (16%)	2 (10%)	3 (16%)	11 (58%)
How is research used to develop health policy?	2 (10%)	0 (0%)	1 (5%)	16 (84%)

Table 27: Fellows' Level of Knowledge Related to Genetics in Health

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No response	Mean
I know how to assess the role of genes for health	0 (0%)	3 (15%)	4 (20%)	10 (50%)	3 (15%)	1 (5%)	3.65
I know how to assess my genetic risk for disease	0 (0%)	2 (10%)	4 (20%)	11 (55%)	3 (15%)	0 (0%)	3.75
I can explain genetic issues to people	0 (0%)	2 (10%)	4 (20%)	10 (50%)	4 (20%)	1 (5%)	3.8

When asked to rate their confidence when they were filling out medical forms by themselves most of the fellows rated that they were "extremely confident" filling out medical forms by themselves (75.0%); whereas 20.0% reported that they were "quite a bit confident" and one fellow (5%) reported that he/she was "somewhat confident." These results were consistent with two additional questions in relationship to health literacy noted below in Table 28.

Table 28: Frequency of Need with Medical Forms (n=19)

	Always (4)	Often (3)	Sometimes (2)	Rarely (1)	Never (0)	Mean
How often do you have someone (like a family member, friend, hospital/clinic worker or caregivers) help you read hospital materials?	0 (0%)	1 (5%)	2 (10%)	5 (25%)	12 (60%)	4.4
How often do you have problems learning about your medical condition because of difficulty understanding written information?	0 (0%)	0 (0%)	1 (5%)	8 (40%)	11 (55%)	4.5

Health Information

Fellows were then asked to comment on how frequently they have received health information through various sources, such as magazines and newspapers, television, and the Internet (see Table 29). Additionally, respondents were asked, "In the past 30 days, how often would you say that you have looked for information about ways to stay health or to feel better?" One respondent has looked everyday, six (35%) have looked several days per week, six (35%) have looked two or three times per month, five (25%) have looked about once a month, and two (10%) have never looked.

Table 29: Frequency Fellows Review Sources for Health Information (n=19)

	Everyday (7)	Several times a week (6)	2 or 3 times a week (5)	About once a month (4)	5 to 10 times per year (3)	Less than 5 times a year (2)	Not in the last year (1)	Mean
Some newspapers or general magazines publish a special section that focuses on health. In the past 12 months, about how often have you read such health sections?	3 (15%)	3 (15%)	3 (15%)	2 (10%)	3 (15%)	3 (15%)	3 (15%)	3.9
Some local television news programs include special segments of their newscast that focus on health issues. In the past 12 months, how often have you watched health segments on local news?	2 (10%)	3 (15%)	1 (5%)	3 (15%)	5 (25%)	2 (10%)	4 (20%)	3.6
Some people notice information about health on the internet, even when they are not trying to find out about a health concern they have or someone in their family has. About how often do you read this sort of health information in the past 12 months?	1 (5%)	0 (0%)	2 (10%)	7 (35%)	5 (25%)	2 (10%)	3 (15%)	3.3

Calculation Skills Self-Assessment

Finally, fellows were asked to rate their ability to work with numbers in various

situations (see Table 30).

Table 30: Fellows' Rating of Ease of use of Numbers (n=19)

Answer	Scale 0-6	Average Value	Standard Deviation
How good are you at calculating a 15% tip?	Not at all good-Extremely good	5.1	1.07
How good are you at working with fractions?	Not at all good-Extremely good	4.6	1.35
How good are you at working with percentages?	Not at all good-Extremely good	4.85	1.23
How good are out at figuring out how much a shit would cost if it is 25% off?	Not at all good-Extremely good	5.35	0.93
When reading a newspaper, how helpful are tables and graphs that are part of the story?	Not helpful at all-Extremely helpful	5.75	0.97
When people tell you the chance of something happening, do you prefer that they use words (e.g it rarely happens) or numbers (e.g there is a 1% chance)?	Always prefer words-Always prefer numbers	4.6	1.88
When you hear the weather forecast, do you prefer predictions using percentages (e.g there is a 20% chance of rain today) or predictions using words only (e.g there is a small chance of rain today)?	Always prefer percentages- Always prefer words	3.25	2.15
How often do you find numerical information to be useful?	Never- Very often	5.7	1.34

Program Assessment

The following set of questions was used to assess the Hattiesburg CRFT program. As

indicated in the final column of Table 31, all means are between 4 and 5, indicating the

respondents, on average, agreed or strongly agreed with all statements relating the success of the

Hattiesburg CRFT program.

Table 31: Program Evaluation (n=19)

Question	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)	No Response	Mean
a. An appropriate amount of material was covered during this training	0 (0%)	0 (0%)	0 (0%)	8 (40%)	12 (60%)	0 (0%)	4.6
b. The facilitators have been prepared and well organized	0 (0%)	0 (0%)	0 (0%)	8 (40%)	12 (60%)	0 (0%)	4.6
c. The facilitators seemed knowledgeable about the subject	0 (0%)	0 (0%)	0 (0%)	7 (35%)	13 (65%)	0 (0%)	4.65
d. The information learned in this training was helpful	0 (0%)	0 (0%)	0 (0%)	8 (40%)	12 (60%)	0 (0%)	4.6
e. The structure and format of the training was beneficial to the learning process	0 (0%)	2 (10%)	0 (0%)	10 (50%)	8 (40%)	0 (0%)	4.2
f. The training location was convenient for me	1 (5%)	0 (0%)	3 (15%)	5 (25%)	11 (55%)	0 (0%)	4.25
g. The timing of the training sessions fit into my schedule	0 (0%)	0 (0%)	1 (5%)	11 (55%)	8 (40%)	0 (0%)	4.42
h. I was satisfied with the training facilities (classroom, meeting scopes, furniture, parking, etc.)	0 (0%)	0 (0%)	1 (5%)	9 (45%)	10 (50%)	0 (0%)	4.45
i. Homework assignments were useful	0 (0%)	0 (0%)	2 (10%)	7 (35%)	11 (55%)	0 (0%)	4.45
j. The amount of homework was appropriate	0 (0%)	0 (0%)	1 (5%)	9 (45%)	9 (45%)	1 (5%)	4.2
k. Homework assignments helped me to better understand the lecture material presented to me	0 (0%)	0 (0%)	2 (10%)	7 (35%)	11 (55%)	0 (0%)	4.45
l. Small group activities and discussion were helpful and beneficial to my learning	0 (0%)	0 (0%)	4 (20%)	6 (30%)	10 (50%)	0 (0%)	4.3

V. Final Social Network Analysis

The CRFT Social Network Analysis Survey was conducted for a second time with the Hattiesburg CRFT fellows following the last meeting of the cohort for the purpose of measuring the growth in the relationships between the CRFT fellows over the 16 weeks of the course. This section compares the network statistics collected at the beginning of the course to those collected at the end of the course.

CRFT fellows were asked about their potential contributions to improving community health. When asked to check all that apply, the majority of respondents (>50%) feel they can contribute through providing objectives to their organization (80.95%), leadership (76.19%), facilitation (71.43%), community connections (66.67%), connections to communities that are experiencing health disparities (57.14%), and broad advocacy for community health priorities (57.14%). Six of the ten options were selected by a majority of respondents. When asked to indicate their single most important contribution, "community connections" was the most frequently selected (33.33%). These responses indicate that respondents recognize the importance of social networks, both between those seeking to improve communities and these individuals' connections to the communities they seek to improve.

Table 32: Contribution to Improving Community Health (n=21)

Response:	Please indicate what you can potentially contribute to improving community health. (Choose all that apply).		What is your single most important contribution to improving community health? (Select one).	
	Pre-CRFT	Post-CRFT	Pre-CRFT	Post-CRFT
Data resources, including data sets, collection and analysis	8 (29.6%)	7 (33.33%)	3 (11.1%)	1 (4.76%)
Providing objectives to my organization	12 (44.4%)	17 (80.95%)	2 (7.4%)	2 (9.52%)
Specific health expertise	10 (37.0%)	9 (42.86%)	1 (3.7%)	1 (4.76%)
Expertise other than in health	9 (33.3%)	8 (38.10%)	2 (7.4%)	0
Community connections	19 (70.4%)	14 (66.67%)	3 (11.1%)	7 (33.33%)
Connection to communities that are experiencing health disparities	15 (55.6%)	12 (57.14%)	7 (25.9%)	2 (9.52%)
Facilitation	9 (33.3%)	15 (71.43%)	5 (18.5%)	2 (9.52%)
Leadership	23 (85.2%)	16 (76.19%)	0 (0%)	4 (19.05%)
Broad activity for community health priorities	12 (44.4%)	12 (57.14%)	1 (3.7%)	1 (4.76%)
Other (please specify)	3 (11.1%)	1 (4.76%)	3 (11.1%)	1 (4.75%)

Similar levels of confidence were reported before and after CRFT in the ability to achieve success in impacting the community (see Table 33).   When asked which aspect of CRFT the fellows believe will help them achieve these goals, all items were selected by a majority of respondents (>50%) (see Table 34).

Table 33: Success in Community Health Impact

Response:	(Pre- Survey) To date, how successful have you been at impacting health in the community?	In the next year, how successful do you feel you will be at impacting health in the community?	
	Pre-CRFT	Pre-CRFT	Post-CRFT
Very Successful	3 (11.1%)	13 (48.1%)	10 (47.62%)
Successful	4 (14.8%)	8 (29.6%)	7 (33.33%)
Somewhat Successful	13 (48.1%)	2 (7.4%)	3 (14.29%)
Not Successful	3 (11.1%)	0 (0%)	0 (0%)
Not Sure	4 (14.8%)	4 (14.8%)	0 (0%)

**Table 34: CRFT Skills for Improving Community Health**

Response:	What aspects of CRFT do you think will help you achieve these goals? (Choose all that apply)	
	Pre-CRFT	Post-CRFT
Brining together diverse individuals	20 (74.0%)	17 (80.95%)
Meeting regularly	14 (51.8%)	11 (52.38%)
Exchanging information/knowledge	21 (77.8%)	19 (90.48%)
Informal relationships created	19 (70.4%)	17 (80.95%)
Grant writing skills	24 (88.9%)	17 (80.95%)
Research skills	22 (81.5%)	16 (76.19%)
Having a shared vision and goals	21 (77.8%)	16 (76.19%)
Collective synergy	15 (55.6%)	11 (52.38%)

After completing the CRFT course, the network cohesion metrics reflect macro-characteristics of the CRFT network as one that is quite connected (see Table 35 and Figure 3). All individuals have connections in the network, with the average respondent have 17 connections. The data provides that the average fellow is connected 17 other fellows after completing the course, whereas fellows were connected to 2 others in the network prior to the course. In fact, 77.5% of the possible connections among fellows exist, which indicates that after CRFT there is a high overall level of connection in the network. The diameter of the network (the largest geodesic distance within the connected network) is two. This indicates that no fellow is more than two steps away from another fellow in the connected network. The average distance of the post CRFT network is 1.109, meaning on average it would take fellows one step to reach all other fellows. These measures are provided next to the baseline statistics in the table below to demonstrate growth attributed to the program.

Table 35: Post-CRFT Social Network Measures of Cohesion (n=23)

Network Measure	Pre-CRFT Statistic	Post-CRFT Statistic
Average Degree	2.111	17.043
H-Index	3	16
Density	0.081	0.775
Components	17	4
Component Ratio	0.615	0.136
Connectedness	0.315	0.870
Fragmentation	0.685	0.130
Closure	0.253	0.908
Average Distance	2.498	1.109
SD Distance	1.279	0.312
Diameter	6	2
Breadth	0.832	0.178
Compactness	0.168	0.822

Figure 3: Post CRFT Sociogram (n=23)
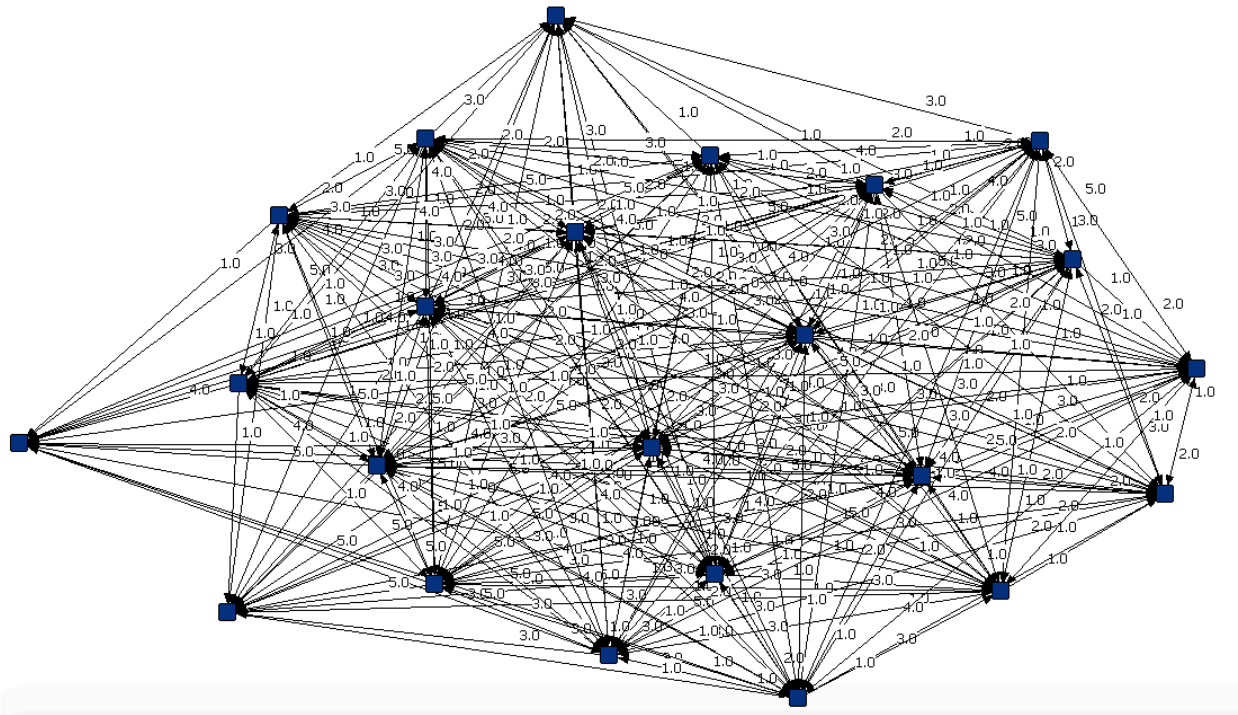
VI. Summary of Program Outcomes

Notable differences include the following:

- Of the 27 fellows who began the program, 23 completed the program

- Prior to participation in CRFT, 48% of respondents reported that they were "extremely confident" filling out medical forms by themselves. Post-CRFT, 75% of respondents felt extremely confident in this task.

- Prior to participating in CRFT, on average, 38.2% of fellows had mastery of the health related terms assessed and 10.7% had basic knowledge, post-CRFT, on average 52.6% of fellows had mastery of the health related terms assessed and 29.9% had basic knowledge.

- After completing the CRFT program, the fellows have developed a strong network, with the average fellow having a relationship with 17 of 22 other graduating fellows.

Following-Up with CRFT Graduates

We will follow-up with the CRFT graduates in May 2017 to assess the ways in which the CRFT skills and networking have been used. As of July 2017, the following updates have been provided (2 months post-graduation):

- Two CRFT fellows attended the Morehouse School of Medicine Community Health Leadership Program in May 2016

- One CRFT fellow used skills learned in the grant writing class to receive a grant from Wal-Mart to purchase book bags for students in the Hattiesburg Public School District

- Six CRFT fellows are now active members of the GSHPC-Hattiesburg Area Health Coalition

- Six CRFT fellows attended the Problem Solving for a Better Health Workshop hosted by the Gulf States Health Policy Center in June 2016

- Five fellows are working with the Hattiesburg Area Health Coalition from September 2016 to June 2017 to conduct CBPR in identified Hattiesburg communities.

Appendix A: Course Syllabus

Mississippi State Department of Health
Office of Health Disparity Elimination
&
Gulf States Health Policy Center

Community Research Fellows Training (CRFT) Program
Course Syllabus

January 19th - May 10th 2016

Jackie Dole Sherrill Community Center
220 W Front Street
Hattiesburg, MS 39401
Tuesdays 6:00-9:00pm

Office Director:
Tanya Funchess, DHA, MPH, MSM
601-206-1540
Email: tanya.funchess@msdh.ms.gov

Project Sponsor
Candace Forbes Bright, Ph.D.
601-266-6545
candace.forbes@usm.edu

Project Coordinator:
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Project Director:
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601-206-1540
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Project Coordinator:
Victoria Walker, MPH
601-206-1540
Email: victoria.walker@msdh.ms.gov

Project Coordinator:
Georgette Powell, BS
601-206-1540
Email: georgette.powell@msdh.ms.gov

Community Research Fellows Training Course Outline

Session 1: Evidence Based Public Health	*January 19*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Vivien C. Carver, Ed.D
• Define evidence based public health. • Identify public resources available for public health.	Professor Emeritus Department of Public Health The University of Southern Mississippi Email: viviencarver@comcast.net
Session 2 : Topic I: Research Methods	*January 26*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Jennifer Lachel Story, PhD, RN
• Define research. • Describe the steps of the research process. • Identify and explain research methodology. • Identify appropriate research methods and techniques. **Topic II: Data** • Define data. • Compare and contrast quantitative and qualitative data. • Compare and contrast primary data and secondary data. • Describe strengths of mixed methods approaches	Associate Professor Assistant Dean for Research and Evaluation The University of Southern Mississippi Email: Lachel.story@usm.edu
NO CLASS	*February 2*
Session 3: Health Disparities	*February 9* *HW 1: Windshield survey Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Tanya Funchess, DHA, MPH, MSM
• Define health disparities. • Identify major health disparities in Mississippi including those by gender, race/ethnicity, geographic location, and socioeconomic status. • Discuss the social determinants of health. • Describe public health strategies and interventions for reducing health disparities.	Director Office of Health Disparity Elimination Mississippi State Department of Health Email: tanya.funchess@msdh.ms.gov

Session 4: **Cultural Competency**	*February 16*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Victoria Walker, MPH
• Define culture and cultural competency. • Describe the need for culturally competent research and practice based on a historical perspective. • Identify skills associated with cultural competent practices.	Director of Health Promotions and Education Office of Health Disparity Elimination Mississippi State Department of Health Email: victoria.walker@msdh.ms.gov
Session 5: **Topic I: Family Health History**	*February 23* *HW 2: Family History Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Ivie Pulliam, MPH, LSW
• Understand importance of collecting and maintaining a family health history. • Understand the role of family health history in healthcare. • Complete a family history chart.	Director of Grants and Reports South Mississippi Rural Health Initiative, Inc. Email: ivie@semrhi.com
Topic II: *Health Literacy*	
By the end of this session, Fellows should be able to meet the following learning objectives:	
• Define health literacy. • Understand the limited literacy perspective. • Describe the association between literacy and health. • Describe health literacy on a national scale.	

Session 6: **Introduction to Epidemiology**	*March 1*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Danielle Robinson Fastring, PhD, MS, MPH
• Define epidemiology. • Identify major contributions of epidemiology. • Identify frameworks for understanding disease processes. • Compare and contrast observational studies vs. clinical trials.	Assistant Professor The University of Southern Mississippi Email: Danielle.Fastring@usm.edu
Session 7: **Community Health**	*March 8*
By the end of this session, Fellows should be able to meet the following learning objectives	Faculty Member: Michael L. Jones, PhD(c), RN, MSN, MBA
• Define community health. • Identify contributing factors that impact the health of a community. • Describe community health activities. • Discuss principals for community based prevention. • Assess the need for a community program.	Chief Community Health Officer University of Mississippi Medical Center Email: mljones2@umc.edu
NO CLASS	*March 15*
Session 8 : **Quantitative Methods**	*March 22* *HW 3: Grocery Audit Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Lei Zhang, PhD, MSc, MBA
• Identify strengths and weaknesses of quantitative methods. • Describe strengths of mixed methods approaches. • Describe stages of questionnaire design. • Identify sampling methods. • Understand usefulness of statistics in health research. • Understand p-values and odds ratios.	Director Office of Health Data and Research Mississippi State Department of Health Email: lei.zhang@msdh.ms.gov

Session 9 : **Community Based Participatory Research**	*March 29* *HW4: Park Audit Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Roma Hanks, PhD
• Describe history and principles of CBPR. • Critically evaluate fellows' position within their community (ies) and their potential roles within CBPR projects. • Describe methods to ensure that CBPR benefits all partners.	Professor and Chair: Sociology, Anthropology, and Social Work University of South Alabama rhanks@southalabama.edu
Session 10: **Qualitative Methods**	*April 5*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Susan Mayfield-Johnson, PhD, MCHES
• Define basic principles of qualitative research methods. • Describe the strengths and weaknesses of qualitative methods. • Discuss different types of qualitative approaches. • Discern when a qualitative research design is desirable.	Assistant Professor The University of Southern Mississippi Email: susan.johnson@usm.edu
Session 11: **Topic I: Photovoice**	*April 12* *Homework 5: Photovoice Part 1 Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Susan Mayfield-Johnson, PhD, MCHES
• Define and discuss concepts of Photovoice. • Understand focus groups and Photovoice qualitative research methods. • Discuss the usage of Photovoice in public health.	Assistant Professor The University of Southern Mississippi Email: susan.johnson@usm.edu
Topic 2: Health Policy	Faculty Member: Eboni E. Edmonson, MSPH, MBA
• Define health policy and health services research. • Identify and develop relevant well framed health policy research questions. • Describe public use and other common data sources for health policy research.	Program Manager Gulf States Health Policy Center ebonibryant@uabmc.edu

Session 12: **Program Evaluation**	*April 19*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Bonita Reinert, RN, PhD, FAAN
• Develop SMART objectives for programs and projects. • Compare and contrast goals and objectives. • Identify culturally competent evaluation approaches. • Understand the importance of evaluation.	Professor Emeritus College of Nursing The University of Southern Mississippi Email: bonita.reinert@usm.edu
Session 13: **Topic I: Research Ethics**	*April 26*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Jerome R. Kolbo, PhD, MSW
• Define research ethics and bioethics. • Compare and contrast clinical ethics vs research ethics. • Identify examples of unethical practices in research. • Understand ethical theories and professional ethical duties. **Topic II:** **Human Subjects' Certification** • Participants will understand the importance of Human Subjects' Certification.	Professor and Social Work Coordinator The University of Southern Mississippi **Email:** jerome.kolbo@usm.edu
Session 14: **Clinical Trials**	*May 3* *Homework 6: Final Photovoice Due*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Kathy Yadrick, PhD,RD
• Understand clinical trials research. • Describe the role of clinical trials research in advancing medical practice. • Discuss the impact of minority participation in clinical trials research.	Associate Dean-Professor The University of Southern Mississippi kathy.yadrick@usm.edu

Session 15: **Grant Writing**	*May 10*
By the end of this session, Fellows should be able to meet the following learning objectives:	Faculty Member: Jennifer Downey, MA
• Understand grant guidelines and requirements. • Understand the power of collaboration for grant writing. • Develop SMART goals and specific Aims. • Understand components of a good grant proposal.	Special Assistant to the Vice President for Research The University of Southern Mississippi Jennifer.downey@usm.edu