Research (MICHR) at the University of Michigan (UM) is working to develop community networks that drive clinical and translational research on community-identified health priorities. METHODS/STUDY POPULATION: These CBRNs will be modeled from successful work that has been accomplished in Jackson, MI where stakeholders from the local healthcare community, County Health Department, Health Improvement Organization, and grassroots community members created a Community of Solution to address the unmet behavioral health and social needs of community members. The CBRN's will focus on identifying community health priorities by receiving input from community members in underserved communities using deliberative software called Choosing All Together (CHAT). RESULTS/ANTICIPATED RESULTS: In the fall of 2017, 3 focus groups were held in Northern Michigan to identify community health priorities. The top 5 community health priorities include; (1) mental wellness, (2) long-term illness, (3) alcohol and drugs, (4) air, water, and land, and (5) affording care. Additional focus groups are scheduled for the winter in 2 additional geographic areas. DISCUSSION/SIGNIFICANCE OF IMPACT: Future work for the creation of CBRNs includes building leadership groups comprised of clinicians, community leaders, public health leaders, health system leaders and researchers to inform the leadership groups of community-identified health priorities. In addition, the team is working to identify a platform to connect academic investigators across UM and community partners on shared research priorities in real time. In order to measure and map relationships within the networks, we are planning to utilize Social Network Analysis as an evaluation tool.

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Community health workers as research advocates

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OBJECTIVES/SPECIFIC AIMS: Background: Failure to involve hard-to-reach populations in clinical research denies the potential benefits of research to the excluded groups, perpetuating health disparities. Employing community health workers (CHWs) may be an effective strategy to increase outreach and engagement of marginalized groups. CHWs are members of the target communities with a personal commitment to help their neighbors, and who serve as informants and communicators among their peers. CHWs may be particularly effective in addressing individual and cultural barriers to research participation. Because of their unique background and community-based roles, tailored training programs for CHWs are needed. The Recruitment, Retention, and Community Engagement Program at the UIC Center for Clinical and Translational Sciences seeks to train CHWs to be involved in the recruitment and enrollment of participants in clinical trials. We developed an 8-hour training that covers basic research methods (e.g., randomized clinical trials, longitudinal studies); research activities (e.g., surveys, interviews); and research ethics. The training focuses on the development of communication skills necessary for ethical recruitment and informed consent, providing strategies for addressing mistrust, fear and misunderstanding around the research process. Aim 1: To evaluate the feasibility of the CHW training by assessing. Aim 1.1: Recruitment of participants; Aim 1.2: Completion of training session (8 hr). Aim 2: To evaluate acceptability of training by assessing. Aim 2.1: Satisfaction with training; Aim 2.2: Cultural competence of training content; Aim 2.3: Participant self-efficacy in reproducing information. Aim 3: To collect performance measures by assessing. Aim 3.1: Knowledge gain and retention; Aim 3.2: Self-efficacy in identifying and addressing negative beliefs about research; Aim 3.3: Participants' readiness to refer and/or recommend participation in clinical trials. METHODS/STUDY POPULATION: Methods: This is a pilot study with a single-group repeated-measures design with assessments at baseline, 1 week post-test, and 3- and 6-month follow-ups. We aim to recruit 25 CHWs working with organizations serving the needs of ethnic minorities in Chicago. We will evaluate feasibility (recruitment, completion of training and assessments) and acceptability of the training (satisfaction with training, cultural appropriateness of content and delivery, participant self-efficacy in reproducing information). Performance measures assessed through self-administered surveys at baseline, 1 week post-training, 3 months, and 6 months will include knowledge, attitudes toward research, and self-efficacy in identifying and addressing barriers to participation. Readiness to recruit and obtain informed consent will be assessed during an observed simulation activity with a standardized participant. Data analysis: Demographic data will be collected, and descriptive and inferential analyses will be conducted. Pretest and post-test questionnaire data will be compared using *t*-tests. In the informed consent simulation, individuals will be scored on whether they adequately addressed required elements of the informed consent process. Data gathered from the informed consent simulation will also be used for program evaluation and formative purposes;

feedback on strengths and areas for improvement will be provided to participants. RESULTS/ANTICIPATED RESULTS: Expected results: It will be feasible to implement the training of CHWs, reaching the expected goal of 25 participants, with at least 70% of them completing the 8-hour training. We expect to collect data demonstrating acceptability of the training with a score of "good" or "excellent" by 70% of participants. At least 70% will rate the training as "culturally acceptable" or better, and will show improved self-efficacy in the delivery of information from pretest to post-test by at least 30%. Performance measures will demonstrate improvements in research knowledge by 30% from pretest to post-test; increased self-efficacy in identifying and addressing negative beliefs about research process, by at least 30%. A minimum of 70% of participants will demonstrate readiness to refer and/or recommend participation in clinical trials by scoring at or above 70% in evaluation of performance with standardized participants. Evaluation of knowledge retention at 3 and 6 months post-training will not take place before the Translational Science Conference in March 2018. DISCUSSION/SIGNIFICANCE OF IMPACT: Discussion/Impact. The outcomes of this evaluation may advance our knowledge of community obstacles to participation in research, and shed light on successful strategies to address them. Information obtained will be used to address limitations of the training. Even though the sample is small we expect to identify trends in quantitative measures that will support an application for funding for a larger randomized study. Once we have developed an effective training model, we expect to disseminate it to other CTSAs for broad implementation.

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Community voices first: A multi-method approach to shaping institutional response to Flint's water crisis

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OBJECTIVES/SPECIFIC AIMS: Explore perceptions of Flint stakeholders on the water crisis regarding trust and the capacity of faith and community-based organizations providing public health services to address community needs. Analyze the community's voice shared at (1) 17 key community communications (community/congressional meetings and events), and (2) during 9 focus group sessions, in which residents, faith-based leadership and other stakeholders discuss issues and concerns on the Flint Water Crisis, and recommend ways to address them. Develop a framework that defines core theories, concepts and strategies recommended by the community to help rebuild trust and the quality of life in Flint, Michigan, and support other communities experiencing environmental stress. METHODS/STUDY POPULATION: Study population: faith-based leaders, seniors, youth, Hispanic/Latino and African American stakeholders, and others experiencing inequities in the city of Flint. Convene 9 focus group sessions (recorded and transcribed) to learn community perceptions on trust and ways to address it. Validate accuracy of the transcriptions with community consultants to reconcile any inaccurate information. Through a community engaged research (CEnR) process, review and analyze qualitative data from the 9 focus group sessions, and quantitative data from 2 surveys documenting (1) demographic backgrounds of focus group participants, and (2) their perceptions on trust and mistrust. Prepare a codebook to qualitatively analyze the focus group data summarizing community input on trust, mistrust, changes in service delivery among community and faith-based organizations, and ways to re-build trust in the city of Flint. Transcribe the community's voice shared during 17 key events, identified by a team of community-academic stakeholders (i.e., UM Flint water course, congressional and community events, etc.), in which residents and other stakeholders discuss issues and concerns on the Flint Water Crisis, and recommend ways to address it. Qualitatively analyze the transcriptions, using a CEnR process to prepare a codebook on key themes from the community's voice shared at these events, and recommendations on ways to address it. Compare and contrast findings between