Pediatric potentially avoidable transfers (PAT) represent a process with high costs and safety risks but few, if any, benefits. To better understand this issue, we described pediatric inter-facility transfers with early discharges. METHODS/STUDY POPULATION: We conducted a descriptive study using electronic medical record data at a single-center over a 12-month period to examine characteristics of pediatric patients with a transfer admission source and early discharge. Among patients with early discharges, we performed descriptive statistics for PAT defined as patient transfers with a discharge home within 24 hours without receiving any specialized tests, interventions, consultations, or diagnoses. RESULTS/ANTICIPATED RESULTS: Of the 2414 pediatric transfers 31.2% were discharged home within 24 hours. Among transferred patients with early discharges, 348 patients (14.4% of total patient transfers) received no specialized tests, interventions, consultations, or diagnoses. Direct admissions were categorized as PAT 2.2-fold more frequently than transfers arriving to the emergency department. Among transferred direct admissions, PAT proportions to the neonatal intensive care unit (ICU), pediatric ICU, and non-ICU were 5.8%, 17.4%, and 27.3%, respectively. Respiratory infections, asthma, and fractures were the most common PAT diagnoses. DISCUSSION/SIGNIFICANCE OF IMPACT: Early discharges and PAT are relatively common among transferred pediatric patients. Further studies are needed to identify the etiologies and clinical impacts of PAT, with a focus on direct admissions given the high frequency of PAT among direct admissions to both the pediatric ICU and non-ICU.

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Risk factors for prescription opioid misuse after traumatic injury in adolescents

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OBJECTIVES/SPECIFIC AIMS: The objective of this study is to determine predictors and motives for sustained opioid use, prescription misuse, and nonmedical opioid use in the adolescent trauma population. METHODS/STUDY POPULATION: This is a prospective cohort study that will follow patients for 1 year and administer surveys to patients on prescription opioid usage; substance use; utilization of pain management and mental health services; mental and physical health conditions; and behavioral and social risk factors. Patient eligibility criteria include: (1) patient is 12–18 years of age; (2) admitted for trauma; (3) english speaking; (4) resides within Indianapolis, IN metropolitan area; and (5) consent can be obtained from a parent or guardian. Patients with severe brain injuries or other injuries that prevent survey participation will be excluded. The patient sample will comprise of 50 traumatically injured adolescents admitted for trauma who will be followed for 12 months after discharge. RESULTS/ANTICIPATED RESULTS: We expect that the results of this study will identify multiple risk factors for sustained opioid use that can be used to create targeted interventions to reduce opioid misuse in the adolescent trauma population. Clinical predictors such as opioid type, dosage, and duration that can be modified to reduce the risk of long-term opioid use will be identified. We expect to elucidate clinical, behavioral, and social risk factors that increase the likelihood adolescents will misuse their medication and initiate nonmedical opioid use. DISCUSSION/SIGNIFICANCE OF IMPACT: Trauma is a surgical specialty that often has limited collaboration with behavioral health providers. Collaborative care models for trauma patients to adequately address the psychological impact of a traumatic injury have become more common in recent years. These models have primarily been concerned with the prevention of post-traumatic stress disorder. We would like to apply the findings of our research to better understand what motivates adolescents to misuse pain medications as well as how clinical, individual, behavioral, and social factors affect medication usage. This may help identify patients at greater risk of developing a SUD by asking questions not commonly addressed in the hospital setting. For example, similar to how trauma centers have mandated brief interventions on alcohol use be performed for center verification, screening patients' on their social environment may identify patients at greater risk for SUD than assumed. The long-term goal would be to prevent opioid use disorders in injured adolescents by providing better post-acute care support, possibly by developing and implementing a collaborative care model that addresses opioid use. Additionally, we believe our findings could be applied in the acute care setting as well to help inform opioid prescribing and pain management methods in the acute phase of an injury. Genetic testing to determine which opioid to prescribe pediatric surgical patients is starting to be done at some pediatric hospitals. Certain genes determine which specific opioid is most effective in controlling a patient's pain and, further, using the optimal opioid medication can also reduce overdose. Our findings may help refine prescribing patterns that could increase or decrease the likelihood of developing SUD in patients with certain genetic, clinical, behavioral, and social characteristics.

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Risk of readmission after discharge from skilled nursing facilities following heart failure hospitalization

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OBJECTIVES/SPECIFIC AIMS: Determine timing of risk of readmissions within 30 days among patients first discharged to a skilled nursing facilities (SNF) after heart failure hospitalization and subsequently discharged home. METHODS/STUDY POPULATION: This was a retrospective cohort study of patients with SNF stays of 30 days or less following discharge from a heart failure hospitalization. Patients were followed for 30 days following discharge from SNF. We categorized patients based on SNF length of stay (LOS): 1–6 days, 7–13 days, 14–30 days. We then fit a piecewise exponential Bayesian model with the outcome as time to readmission after discharge from SNF for each group. Our event of interest was unplanned readmission; death and planned readmissions were considered as competing risks. Our model examined 2 different time intervals following discharge from SNF: 0–3 days post SNF discharge and 4–30 days post SNF discharge. We reported the hazard rate (credible interval) of readmission for each time interval. We examined all Medicare fee-for-service (FFS) patients 65 and older admitted from July 2012 to June 2015 with a principal discharge diagnosis of HF, based on methods adopted by the Centers for Medicare and Medicaid Services (CMS) for hospital quality measurement. RESULTS/ANTICIPATED RESULTS: Our study included 67,585 HF hospitalizations discharged to SNF and subsequently discharged home [median age, 84 years (IQR; 78–89); female, 61.0%]; 13,257 (19.2%) were discharged with home care, 54,328 (80.4%) without. Median length of SNF admission was 17 days (IQR; 11–22). In total, 16,333 (24.2%) SNF discharges to home were readmitted within 30 days of SNF discharge; median time to readmission was 9 days (IQR; 3–18). The hazard rate of readmission for each group was significantly increased on days 0–3 after discharge from SNF compared with days 4–30 after discharge from SNF. In addition, the hazard rate of readmission during the first 0–3 days after discharge from SNF decreased as the LOS in SNF increased. DISCUSSION/SIGNIFICANCE OF IMPACT: The hazard rate of readmission after SNF discharge following heart failure hospitalization is highest during the first 6 days home. Length of stay at SNF also has an effect on risk of readmission immediately after discharge from SNF; patients with a longer length of stay in SNF were less likely to be readmitted in the first 3 days after discharge from SNF.

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Shared decision making in child health: A qualitative study of parents of children with medical complexity

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OBJECTIVES/SPECIFIC AIMS: Children with medical complexity (CMC) comprise less than 5% of the pediatric population and over 40% of pediatric spending, yet receive poorer quality health care compared with other children. The American Academy of Pediatrics recently identified shared decision making (SDM) as a key quality indicator for CMC, but there is no consensus model for SDM in CMC. Objective: To create a model of SDM from perspectives of parents of CMC. METHODS/STUDY POPULATION: Interviews with parents of CMC explored SDM preferences and experiences. Eligible parents were ≥18 years old, English-speaking or Spanish-speaking, with a CMC <12 years old. Interviews were recorded, transcribed, and analyzed by 3 independent coders for shared themes using grounded theory. RESULTS/ANTICIPATED RESULTS: Interviews were with 31 parents [26 English speakers, median parent age 33 years (SD 11), median child age 3 years (SD 3.6)] in inpatient and outpatient settings. We identified specific, unique components of SDM that affect decision quality, the alignment of a decision with the parent's preferences and values. Themes included: concerns about uncertainty of the child's life trajectory, conflict during parent-provider communication, health system factors such as provider schedule; parent agency, and the influence of the source of information. DISCUSSION/SIGNIFICANCE OF IMPACT: Our findings provide specific components of SDM unique to CMC that can inform future research and interventions to support SDM for parents and providers of CMC.