

morbidity. **DISCUSSION/SIGNIFICANCE OF IMPACT:** This study, to our knowledge, is the first to look at maternal morbidity in this population. Additionally, this study seeks to move current research from examining infant outcomes at birth among mothers experiencing homelessness to understanding the maternal morbidities during this period. Long term, good maternal health has significant implications for the health of a mother's future pregnancies and a risk reduction of adverse chronic conditions. Study results will provide the preliminary knowledge needed to guide further research leading to clinical approaches that promote better maternal health in this population. Lastly, the study findings will inform policy by characterizing the quality and strength of evidence of the adverse maternal health effects associated with the experience of homelessness.

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Time to Diagnostic Resolution After an Abnormal Screening Mammogram: a Single-Center Experience in an Underserved Hospital

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OBJECTIVES/SPECIFIC AIMS: The study aims to identify patient and provider factors associated with delay in diagnostic resolution after an abnormal screening mammogram, with an emphasis on whether patients who spoke Chinese as their primary language sustained longer times to resolution. Primary outcome is to identify what proportion of patients achieve diagnostic resolution after abnormal screening mammogram within 90 days. Secondary outcome is to identify whether Chinese-speaking patients experience longer times to diagnostic resolution. **METHODS/STUDY POPULATION:** We performed a single-center retrospective cohort study at Tufts Medical Center (TMC), a tertiary care hospital that serves as the primary referral site for the Chinatown neighborhood in Boston. We included patients who underwent screening mammogram between 10/1/2015-9/30/2016 which was resulted as BIRADS-0 (non-diagnostic). Diagnostic resolution was defined as BIRADS-1, 2, or 3 imaging or definitive biopsy. We collected data on patient demographics (age, insurance plan, race/ethnicity, primary language, history of cancer), provider characteristics (referring provider location), and post-referral testing. Insurance was categorized as private-only or subsidized. Poverty was categorized using the American Fact Finder database, with a binary variable of <20% of ≥20% people in poverty for a given zip code. We performed descriptive statistics for all variables. We will perform multivariable Cox regression analyses to determine whether Chinese-speaking patients experience longer time to diagnostic resolution, adjusting for age, referring provider type, insurance status, poverty, and breast cancer history. We will use $p < 0.05$ for our threshold for significance. **RESULTS/ANTICIPATED RESULTS:** We identified 386 patients who met inclusion criteria. Over half (55.9%) of patients were Caucasian, the mean age of study patients was 59 years, and 22% of patients were classified as poor. English was the most commonly spoken primary language (77.7%), while 15.3% of patients identified a Chinese dialect as their primary language. Most patients solely used private insurance for their medical care (73.1%). Majority of patients (83%) presented after undergoing a routine screening mammography, but a considerable proportion (14.4%) had prior breast cancer or a

palpable mass. Most patients were referred for their screening mammogram by a hospital-based provider at TMC (85%), of which 77% of TMC referrals were from primary care. We also noted a limited number of referrals from community health centers, private practices and other PCP's (Table 1). We will calculate median time to diagnostic resolution after screening mammogram and the proportion of patients who achieve resolution within 90 days. We will also calculate time to initiation of diagnostic workup, and whether this differed among Chinese-speaking patients, subsidized patients, or among those who were referred from outside of TMC. We will complete Cox multivariable analysis to identify if Chinese-speaking patients experience longer time to diagnostic resolution, adjusting for age, insurance status, Primary care provider location, poverty, and prior history of breast cancer. We will a priori test for an interaction between primary care provider within Tufts and Chinese as primary language to identify if a PCP within TMC modifies the relationship between Chinese language and time to resolution. **DISCUSSION/SIGNIFICANCE OF IMPACT:** The proposed study will identify whether disparities exist in time to achieving diagnostic resolution. Specifically, we will identify if patients who are primarily Chinese-speaking experience longer time to resolution. Our results will potentially provide the foundation for a patient navigation program to attenuate existing disparities by providing additional support for Chinese speaking patients in breast imaging workup.

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Translating the complex medical jargon of opioid use disorder and medication assisted treatment into locally relevant messages in rural Colorado using Boot Camp Translation

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OBJECTIVES/SPECIFIC AIMS: Opioid use disorder (OUD) is a national epidemic and identified as a top priority by the practices and communities in rural Colorado. Until recently, few resources existed to address OUD in rural communities. In addition to training primary care and behavioral health practice teams in medication assisted treatment (MAT), Implementing Technology and Medication Assisted Treatment and Team Training and in Rural Colorado (IT MATTTRs Colorado) engaged local community members to alter the community conversation around OUD and treatment. For IT MATTTRs, the High Plains Research Network and the Colorado Research Network engaged community members in a 8-10 month process known as Boot Camp Translations (BCT) to translate medical information and jargon around OUD and MAT into concepts, messages, and materials that are meaningful and actionable to community members. The resulting community interventions are reported here. **METHODS/STUDY POPULATION:** IT MATTTRs conducted separate BCTs in Eastern Colorado and the south central San Luis Valley. Community partners included non-health professionals with diverse backgrounds, public health and primary care professionals, law enforcement, and others. The BCT process includes a comprehensive education on OUD and MAT and facilitated meetings and calls to develop messages and dissemination strategies. Each BCT lasted around 8-10 months. **RESULTS/ANTICIPATED RESULTS:** The BCT process elicited unique contextual ideas and constructs for messages, materials, and dissemination strategies. Themes common to

both BCTs include the prevalence of OUD and that help is available in the local primary care office. Community-tailored messages are distributed through posters and flyer inserts, drink coasters, newspaper articles, letters to local judges, restaurant placemats, and websites. Examples of the materials and messages will be presented. **DISCUSSION/SIGNIFICANCE OF IMPACT:** Local community members are eager to help address the OUD crisis. Built on community-based participatory research principles, BCT can be used to translate complex information and guidelines around OUD and MAT into messages and materials that reflect local culture and community needs.

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Trust in Research Among Older Adults

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OBJECTIVES/SPECIFIC AIMS: Adults, 60 years of age and older, are in high demand for enrollment in many types of health research. Here we aimed to examine baseline, 60-day and 120-day follow-up trust in research and researchers of Floridians 60 years of age and older engaged in University of Florida's HealthStreet community engagement initiative. **METHODS/STUDY POPULATION:** HealthStreet Community Health Workers (CHWs) assess health needs and trust in research of community members and screen for dementia, before providing medical and social services referrals and linkages to opportunities to participate in relevant health research at UF. In addition, participants are followed up at 60 and 120 days. **RESULTS/ANTICIPATED RESULTS:** Among the 2,193 older adults assessed by CHWs, 62.6% were female, 46.8% were African American, and 6.1% Hispanic/Latino. At baseline, 28.3% reported ever being in a research study; 7.7% reported not being interested in participating in research. Trust in research and researchers was high at baseline [scored from 1 to 10 where 10 was high; mean of 7.4 each for trust in research (SD=2.0) and trust in researchers (SD=2.1)] and high at both follow-ups [60 days 7.8 (SD=2.1) and 7.7 (SD=2) for trust in research and researchers respectively; 120 days 8.0 for both (SD=1.9 and 1.8 respectively)]. **DISCUSSION/SIGNIFICANCE OF IMPACT:** Individuals who are 60 and older have high trust in research and researchers when approached and high interest in research. Their trust continues through work with HealthStreet CHWs. Community engagement is an important part of the pipeline for recruitment of older adults for research.

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Understanding Community-engaged Research at an Academic Medical Center and Learning Healthcare System in the US South

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OBJECTIVES/SPECIFIC AIMS: Wake Forest Baptist Health (WFBH) is an Academic Learning Healthcare System (aLHS) serving 24 counties in North Carolina and Virginia. Like many aLHSs,

WFBH experiences strained community relationships attributable to a history of medical and research abuses against marginalized populations. This legacy accompanies longstanding community mistrust in the healthcare system and research. To overcome these challenges, community-engaged research (CEnR) approaches have potential to repair community-academic relationships, improve public health, and empower groups that traditionally have been neglected by or overlooked in research. To develop and revise our understanding of how CEnR is harnessed at WFBH, semi-structured interviews were conducted with investigators and study staff experienced in CEnR approaches. In-depth interview guides were designed iteratively to capture socio-contextual and detailed descriptions of perceptions, experiences, and strategies specific to the use of CEnR. **METHODS/STUDY POPULATION:** A keyword search performed within WFBH study records identified 51 investigators whom had submitted research proposals related to CEnR within the past ten years. Sixteen were confirmed eligible based on a review of proposal abstracts, of which 14 responded to email invitations agreeing to participate. Four additional participants were referred by initial participants. Eighteen investigators (16 faculty and 2 research associates) provided consent and completed Interviews. **RESULTS/ANTICIPATED RESULTS:** The participant sample was 50% female with a mean age of 55 years, 11% Black and 89% White, with representation across various academic backgrounds (e.g., anthropology, medicine, psychology, and public health) A majority of participants (89%) hold doctoral degrees (i.e., PhD, DrPH, EdD, MD, and MD-PhD). On average, participants had been employed at WFBH for 13.9 years, and represented various departments including dermatology, epidemiology and prevention, family medicine, neurology, social sciences and health policy, and psychiatry. Nearly all participants (89%) indicated they had never received formal education or training in CEnR, though 100% reported "on-the-job" training in CEnR. Interviews were audio-recorded, transcribed, coded, and analyzed following an inductive thematic approach, from which twenty-two themes emerged across six domains related to CEnR (Table 2), including: Conceptualization and Purpose, Value and Investment, Community-Academic Partnerships, Sustainability, Facilitators, and Challenges. Results also provided key characteristics that define CEnR (Table 3), and yielded 11 emerging needs necessary to enhance CEnR within aLHSs (Table 4). **DISCUSSION/SIGNIFICANCE OF IMPACT:** The results of this study provide information critical to understanding how CEnR frameworks and approaches can be harnessed not just in Schools of Public Health, but within aLHSs to build and repair community-academic partnerships, inform research and institutional priorities, and address community health concerns. Despite the small sample size, the number of participant interviews was sufficient to achieve saturation while also providing broad and unique perspectives across various fields and CEnR approaches. Overall, participants conceptualized the purpose and goals of CEnR quite similarly, though there was a great deal of variance in how CEnR was defined and operationalized across interviews, indicating a need to more clearly articulate important features that enhance understanding of what CEnR is and what it is not (Table 3). These discrepancies and inconsistencies indicate a potential need for additional formal training in the understanding and use of CEnR approaches, which is supported by the fact that nearly all participants reported receiving no formal training in CEnR. Across all interviews, participants expressed a need for health care providers and researchers to better understand community contexts, social determinants of health, and historical factors influencing