impact of factors influencing medical eligibility for HCV treatment. By establishing predictors of linkage outcomes, we hope to characterize patients at highest risk of being lost to follow-up. This information can be used to guide the development of targeted interventions and optimize linkage efforts at institutions with similar programs. METHODS/STUDY POPULATION: In 2013, we implemented an opt-out HCV screening program targeting baby boomers presenting to the ED. The screening program was expanded in 2015, and all patients who presented to the ED (an academic ED with 73,000 annual visits) between 2015 and 2018 were offered an HCV antibody test. Confirmatory RNA tests were ordered for all patients with a positive screening test, and those with confirmed infection were contacted (when possible) by a linkage coordinator, who sought to facilitate linkage to outpatient care. Patients were followed until they had been successfully linked to care or were lost to follow-up; successful linkage was defined as a patient attending a scheduled HCV clinic visit. Linkage outcomes (linked vs. not linked) among confirmed cases were analyzed based on previously described LTC barriers, sociodemographic factors, and factors influencing HCV treatment eligibility. Binary multiple logistic regression was used to model the relationship between predictors and LTC outcomes. RESULTS/ANTICIPATED RESULTS: Between August 2015 and June 2018, 48,947 patients were screened for HCV, yielding 4,026 positive results. HCV infection was confirmed in 1,798 patients, 1,651 of whom were eligible for the current study. By July 2018, 884 eligible patients (53.5%) had been successfully linked to care. Odds of linkage failure were decreased among patients with known linkage barriers including mental health disorders (adjusted odds ratio [aOR], 0.28; 95% confidence interval [CI], 0.21-0.37), active substance abuse (aOR, 0.65; 95% CI, 0.47-0.91), and 'competing' medical comorbidities (aOR, 0.31; 95% CI, 0.21-0.47); however, odds of linkage failure were increased in the presence of medical comorbidities leading to ineligibility for HCV treatment (aOR, 21.71; 95% CI, 7.02-67.13). Decreased odds of linkage failure were also found among patients belonging to the baby boomer population (aOR, 0.64; 95% CI, 0.46-0.91) and individuals with HBV co-infection (aOR, 0.36; 95% CI, 0.14-0.94). Finally, odds of linkage failure were increased among patients without health insurance (aOR, 1.952; 95% CI, 1.01-3.79) and with public health insurance (aOR, 2.140; 95% CI, 1.08-4.24). While African-American patients exhibited decreased odds of linkage failure in bivariate analyses, this association was not significant in the multivariate analysis. Variables ultimately found not to be predictive of linkage outcome included race, ethnicity, gender, homelessness, and incarceration. DISCUSSION/SIGNIFICANCE OF IMPACT: In contrast with current trends in the literature, our analysis found that patients with any of three well-described linkage barriers (mental health disorder, active substance abuse, and 'competing' comorbidities) exhibited decreased odds of linkage failure. It is possible that knowledge of these barriers by linkage personnel led to increased persistence of efforts for such patients, resulting in improved linkage among patients with these barriers. However, another possibility is that individuals with factors such as a mental health disorder or medical comorbidity were more likely to experience a clinical encounter, during which discussions about HCV treatment could take place. It is also possible that other contributing factors were unaccounted for by our analysis, such as internal programmatic issues, patient education and income levels, marital status, or other 'destabilizing' factors that would reduce a patient's likelihood of being contacted by a linkage coordinator. While patients with general medical comorbidities were less likely to experience linkage failure, patients who were ineligible for HCV treatment due to a medical comorbidity were significantly more likely to experience linkage failure. While this finding is intuitive, it is nonetheless troubling, as we would expect patients with severe medical comorbidities to benefit greatly from health counseling, mental health services, substance abuse treatment, or other resources available through linkage. As a result of this finding, we intend to adapt our approach to medically ineligible patients, emphasizing the availability and potential usefulness of such resources. It is unsurprising that uninsured and publicly insured patients were less likely to be successfully linked to care, as HCV treatment continues to be associated with significant financial costs for such patients. However, it is also possible that confounding factors such as education and income level, which were not included in our analysis, would be more predictive of patients' ability or willingness to undergo HCV treatment. More research is needed to improve linkage-to-care for patients with HCV. In the near future, we intend to conduct an internal evaluation, as well as a positive deviance analysis of other LTC programs, to determine additional ways to improve linkage outcomes for all patients screened for HCV in the ED.

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Quantifying the psychosocial benefits of masculinizing chest reconstruction in transgender men with patient reported outcomes: The GENDER-Q

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OBJECTIVES/SPECIFIC AIMS: 1. To evaluate the effects of masculinizing chest reconstruction on the quality of life of female-to-male transgender individuals. 2. To develop and validate a quality of life survey for female-to-male transgender individuals undergoing masculinizing chest reconstruction gender-affirming surgery. METHODS/STUDY POPULATION:. We developed and refined the GENDER-Q using focus groups and exploratory interviews with FTM individuals that were recorded, transcribed, and coded. All consenting FTM patients undergoing chest reconstruction at UCSF Parnassus Medical center between 2017-2019 who meet World Professional Association for Transgender Health (WPATH) criteria for gender dysphoria will be enrolled in the study. The GENDER-Q will be co-administered with the WHO Quality of Life-BREF survey pre-operatively, 6 weeks post-operatively, and one year post-operatively through REDCAP, an online survey database. RESULTS/ANTICIPATED RESULTS: Approximately 70 patients will be enrolled in the study. Preliminary results detect statistically significant mean quality of life post-operative improvements in all three sections (Physical Health, Gender Presentation, Psychological Health) of the GENDER-Q at 6-week follow up that is maintained at one-year ($p < 0.005$). Statistically significant improvements were similarly achieved and maintained with the WHO QOL-BREF survey ($p < 0.05$). The mean reported improvement from baseline to follow-up appears to be more pronounced in the GENDER-Q survey compared to WHO QOL-BREF. The median time to complete the pre and post-operative surveys was 10 minutes. Calculation of Cronbach's (0.67-0.81) and the Pearson Correlation Coefficient for each section revealed excellent internal validity. DISCUSSION/SIGNIFICANCE OF IMPACT: There are few studies assessing quality of life outcomes in transgender patients undergoing gender-affirming surgeries. A standardized and validated assessment tool will provide the means for which data can be pooled in large multi-center studies. Providing further evidence to support the positive health outcomes of gender-affirming surgeries can lead to broader access and reduce healthcare disparities among transgender populations.

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