management measures (e.g., A1C and BP monitoring). We categorized insurance stability status during each 6-month interval as 6 separate categories based upon type (private, public, uninsured) and continuity of insurance (continuous, switches, or gaps in coverage). We will examine the association between insurance stability status and DM outcomes adjusting for time, age, sex, comorbidities, site of care, education, and income. Additional analysis will examine if insurance stability moderates the impact of race/ethnicity on DM outcomes. RESULTS/ANTICIPATED RESULTS: Overall, we anticipate that stable health insurance coverage will improve measures for DM care, particularly for racially/ethnically diverse patients. DISCUSSION/SIGNIFICANCE OF IMPACT: The finding of an interaction between insurance stability status and race/ethnicity in improved diabetes management and control would inform the national health care policy debate on the impact of stable health insurance.

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The role of community in an evolving community-university pilot award program

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OBJECTIVES/SPECIFIC AIMS: To fulfill the Indiana Clinical and Translational Sciences Institute's (Indiana CTSI) Community Health Partnerships' (CHeP) mission of improving the health of Indiana residents through community-university partnerships, CHeP engaged with community partners to develop and implement a pilot award program for community-based participatory research, the Trailblazer Award (TA). The objective is to describe the engagement processes throughout the pilot program timeline and as the pilot program evolved over the 6-year period since the program started. METHODS/STUDY POPULATION: Though a process of engagement with community stakeholders, we assessed the process for each year of the TA, noting what changes occurred and how they occurred. Engagement for the TA process occurred during the following phases: RFA development, review, active project support, dissemination of project results, and project/partnership follow-up. RESULTS/ANTICIPATED RESULTS: During the RFA development phase, we decided to focus the award on health equity for 5 years; and we implemented structural changes to encourage new partnerships in underrepresented and rural areas. During the review phase, we incorporated both community and university reviewers and co-moderators. To increase capacity among our reviewer pool, we offered webinars and repeated opportunities to serve as reviewers. During the project support phase, we added the following: community-based CITI training; opportunities for networking with peer awardee teams; and community and academic co-led sessions on addressing recruitment barriers, grant writing, and dissemination to a community audiences. Through our active engagement of the CHeP Advisory Board, one Board member (from Indiana State Department of Health) leveraged matching funds for the TA, effectively doubling the number of projects supported each year. DISCUSSION/SIGNIFICANCE OF IMPACT: Whereas previous work has reported on engagement during the review process of pilot award applications, we discuss ways to extend engagement to include other aspects of a pilot program both before and after the review process. In our process, several key partners offered insightful changes that have resulted in a more engaged program.

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The value of storytelling in community stakeholder feedback for clinical and translational research

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OBJECTIVES/SPECIFIC AIMS: Community stakeholder engagement along the translational spectrum of biomedical research has been identified as a potentially crucial factor for encouraging participation among underrepresented groups, improving research relevance, and adoption of evidence into practice. Although we have developed various methods to improve communication between researchers and community stakeholders, we have not focused much attention on the manner by which community stakeholders choose to communicate with researchers in scientific feedback settings. In our PCORI funded study using Community Engagement Studios to elicit feedback on research from community stakeholders, we found that feedback from participants was frequently provided in the form of stories. This presentation aims to describe these narratives, examine their function in the feedback process and consider how a focus on these narratives enhances our understanding of community engagement for clinical and translational research. METHODS/STUDY POPULATION: The present study comes from a larger randomized, controlled methodological study. We randomized 20 investigators seeking input on their research to either a Community Engagement Studio (a panel of community members or patients) or a Translational Studio (a panel of researchers). Any faculty member or research trainee at Vanderbilt University or Meharry Medical College was eligible to participate. Each Studio panel was convened to provide project-specific input. The 153 stakeholders who participated in CE Studios were patients, caregivers, or patient advocates identified by health status, health condition, or demographic variables based on the project-based needs of the 20 researchers randomized in this project. Stakeholders include individuals with diabetes, heart failure, Parkinson's disease, sickle cell disease, and ICU survivors. All stakeholders had experience as a partner or consultant on a research project or through serving on a research advisory board or committee. All Studios were recorded and transcribed, and experienced qualitative researchers analyzed the data. For this paper, we focus on the narrative feedback in the form of stories elicited in the CE Studios. Using qualitative methods, we coded the transcripts from the 20 CE Studios to identify stories and their functions in the feedback. Stories were defined as narratives with (a) at least one actor (b) action that unfolds over time, and (c) a realization, destination, or conflict resolution (i.e., a point of the story). For example, "I refilled my mother's pillbox on Sunday and on Friday I found the pillbox still completely full" would be a story, however, "my mother doesn't take her meds correctly" would not. We coded the stories for how they facilitated communication in the Studio using an open-coding style, that is we did not apply a specific theoretical framework of interaction or communication. It was possible for any given story to have more than one code applied to it; that is they were not classified in a mutually exclusive way. RESULTS/ANTICIPATED RESULTS: We found 5 major functions of stories in the Studios. Basic sender-receiver functions were noted, including responding to queries and seeking mutual understanding. The other functions served to move or add to the conversation, including adding expansion and depth, characterizing abstract concepts, and providing context, with the latter being the most frequent function of stories. Speakers provided context in a wide variety of dimensions, ranging from the context of the body to spatial and institutional contexts. These stories served to help others understand the speakers' lived experiences. DISCUSSION/SIGNIFICANCE OF IMPACT: We often engage community members in research for their expertise with regards to their lived experiences as patients or community members, and for their experiences of healthcare and social determinants of health in particular community contexts. Yet we may expect them to share their expertise in a manner that is consistent with a scientific, explanatory framing and language. However, we know there is a difference in the way that professional researchers discuss research Versus how community members discuss research. In our PCORI study, we found that our Community Studio participants relied on storytelling as an important means to communicate their lived experiences. Their stories were often key to communicating the complex contexts of their experiences. We focus on examining these narrative practices and their functions in how community members engaged with and provided advice to researchers. This understanding may help us in: (1) Characterizing the contexts, processes, and meanings associated with community stakeholder experiences that are otherwise difficult to access. (2) Identifying community priorities relevant to research that are embedded in community narratives to better align research priorities with community needs and to improve patient outcomes. (3) Collecting insights for improving the design of community engagement activities in research. (4) Harnessing more fully the potential of community engagement in research.

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Tool to assess opportunities to augment health literacy and culturally responsive components of research design to enhance diverse engagement

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OBJECTIVES/SPECIFIC AIMS: The goals of this project are to: (1) Help research teams better understand, anticipate, and adapt research to address the needs of

diverse communities. (2) Help clinicians and researchers develop patient-centered communication skills needed for more frequent and meaningful engagement of research participants. (3) Identify additional service support needs of clinical research teams not currently offered by other centers (e.g., translation services by certified translators, access to bilingual/bicultural research staff) so they can effectively recruit diverse communities. METHODS/STUDY POPULATION: Mixed methods evaluation approaches centered on obtaining community and academic input aimed at revising the tool to enhance its feasibility and relevance. Round one of focus groups were conducted (4), 2 with a diverse group of community stakeholders, 2 with a diverse group of academic stakeholders. Focus group feedback guided HLCR Assessment Tool revisions. This round of focus groups, served as an opportunity for community and academic stakeholders to discuss shared and divergent priorities related to the development and utilization of the tool. Feedback from these sessions guided a second set of revisions to the tool. Brief surveys were administered at each time point to gather participant demographic data. For the first round of focus groups with community stakeholders, 2 diverse groups totaling 19 people participated (11 female, 7 male, 1 no answer; 6 Asian/Pacific Islander, 6 Black/African American, 4 Latino/Hispanic, and 3 White/Caucasian). Participants served a variety of populations including seniors, youth, underserved, Muslim Americans, Bangladeshi, Arab, South Asian, refugees, community health centers, service organizations, 1st generation students, Latinos, multi-ethnic groups, limited English speaking, people with lupus, un/underinsured, people with HIV, Korean Americans, African Americans, and the disability community. Data pending on the first round of focus groups with academic stakeholders. All participants of the first round of focus groups will be invited to return to a second round of focus groups (2), this time only 2 groups will be held, and these will combine community and academic participants in each focus group. RESULTS/ANTICIPATED RESULTS: Along with formatting and grammatical revisions, recurring recommendations focused on considerations/clarifications in 3 main areas: compensation for all stakeholders, developing a common language and clarifying terms, and aligning the research process with the community. Considerations around compensation was mentioned in discussions related to multiple tool domains. In particular, community stakeholders recommended inclusion and consideration of compensation not just for research participants but also community partners, sites, community representatives, and other academic partners. It was also very important to make sure the form of compensation for both community partners and participants aligns with what was being asked of them. Community stakeholders sited a few examples where they were involved in studies where the time and requirements for participation were not commensurate with the compensation they received or the study budget did not include compensation for community partner effort. Along with edits to questions in the HLCR Assessment Tool, community stakeholders also recommended education for budget/finance personnel on fair compensation for research participants and community partners. In both focus groups, there was also confusion around specific terms and an identified need to develop a common language and clarify terms among all those involved in the research process. More specifically, terms such as community, culture, community of focus, community partners, accessible, and convenient were identified as needing further definition or clarification. Through the focus groups, we learned the valuable lesson that it cannot be assumed broad terms or even seemingly specific ones will be interpreted the same by everyone or have the same meaning in different contexts. Therefore, it needs to be very clear what these terms mean and who or what they represent. Finally, the community stakeholders emphasized throughout both focus groups the importance of making sure that the HLCR Assessment Tool unpack and explicitly emphasize how the research process can align and should align with community needs, communication structures, influencers, and assets. Some factors community stakeholders suggested be considered were: (1) Where the researcher is in the research process; (2) How community members prefer to communicate with each other; (3) Stigma/biases (e.g., class) that may be pervasive in a particular community; (4) Identification of key community influencers/gatekeepers; (5) Learning about a community's assets along with their needs. DISCUSSION/SIGNIFICANCE OF IMPACT: Currently, there is dearth of resources focused on increasing diverse engagement in clinical and translational research, and consequently, research teams have little or no knowledge or support for how or when to engage community partners in clinical or translational research. The goal of this project is to help fill that gap with a tool to guide clinical and translational research teams in assessing the health literacy and culturally responsive components of their research projects to improve recruitment of diverse populations. Feedback on the first iteration of the HLCR Assessment Tool helped us identify the priorities for community stakeholders and better understand their concerns and needs around engagement with academic partners in clinical and translational research. This understanding will help us enhance the relevance and usefulness of the HLCR Assessment Tool so that clinical and translational science researchers more effectively engage with community partners and help ensure the community's needs are better aligned with. Therefore, developing and pilot testing this tool can offer a significant opportunity for clinical and translational sciences institutions to enable their researchers and their teams to teams better understand, anticipate, and adapt to the cultural and health literacy needs of diverse populations. More specifically, this tool can: (1) Help clinicians develop the patient-centered communication skills needed to facilitate more frequent and meaningful engagement of potential research participants during medical visits to truly make every healthcare encounter an opportunity for research. (2) Help clinical and translational sciences institutes identify additional service support clinical research teams will need access to in order to effectively recruit diverse communities, that are not currently not supported [e.g., translation services by certified translators, access to bilingual/bicultural research staff at all level (i.e., study coordinators, research assistants, etc.), etc.].

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Understanding the health effects of binding and tucking for gender affirmation

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OBJECTIVES/SPECIFIC AIMS: Gender affirmation is a critical aspect of the health and well-being of transgender individuals. For many transgender people, this includes changing one's physical appearance to align with one's felt gender. Some gender-affirming body modifications require medical interventions such as hormone therapies and surgeries. Other modifications, such as tucking to create a flat-appearing lower pelvis and binding to create a flat-appearing chest, require no external intervention. The published literature is slowly growing on the health effects of gender affirming medical interventions; however, other body modifications are understudied. As part of our needs assessment of the transgender community, we sought to understand the frequency and health impact of binding and tucking. METHODS/STUDY POPULATION: A quantitative online survey was developed based on qualitative interviews with 20 community-based key informants. The survey was available online, in English, for 6 months. Eligible participants were 18 years of age or older, lived in the Baltimore metropolitan area, and identified as transgender and/or a sex different from what was assigned on their original birth certificate. RESULTS/ANTICIPATED RESULTS: 139 participants provided complete data: 45% were assigned male at birth (AMAB) and 55% were assigned female at birth (AFAB). In total, 54% were Black, 40% White, and 9% Latinx. Of AFAB participants, 80% had bound their chest tissue. Of those who had bound, 51% bound 7 days/week, 62% bound 8 + hours per day, and 68% were concerned about the health effects of binding. The most common symptoms associated with binding were back pain (65%), shortness of breath (48.6%), bad posture (32%), chest pain (30%), and light-headedness (30%). Of AMAB participants, 71% had ever tucked, 85% of those tucked 7 days per week, 79% tucked 8 + hours per day, and 50% were concerned about the health effects of tucking. Most common symptoms included itching (28%), rash (21%), testicular pain (17%), penile pain (14%), and skin infections (12%). DISCUSSION/SIGNIFICANCE OF IMPACT: The majority of transgender participants used binding or tucking for gender-affirming body modification and at least half of them have concerns about associated health effects. Clinicians should ask transgender patients about binding and tucking behaviors and assess for common symptoms. More research is needed to better understand the benefits and risks of gender-affirming binding and tucking behaviors.

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Validation of a set of "healthcare trust" scales for women seeking substance abuse treatment in community-based settings

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OBJECTIVES/SPECIFIC AIMS: To validate previously published psychometric scales capturing interpersonal or healthcare-related trust in a target population of women with a history of substance use disorder seeking substance abuse treatment in a community-based setting. METHODS/STUDY POPULATION: Participants are enrolled at The Next Door, Inc. (TND) and Renewal House (RH), 2 community agencies in metropolitan Nashville that provide substance abuse treatment and post-incarceration re-entry services for women with a history of substance use disorder. We will enroll 300 participants to provide sufficient power for statistical psychometric validation. Inclusion criteria include adult women with self-identified history of substance use disorder seeking substance abuse treatment within seven days of initiation of inpatient residential or intensive