

refugees. Common barriers to research participation that we expect are mistrust, financial constraints, fear of unintended outcomes, stigma about participating in research, and fear of deportation or concern of immigration status. We plan to address these barriers by hiring bilingual Somali recruiter/interviewer, translating study materials, reassuring confidentiality of participant's information, providing a \$50 incentive, and implementing community advisory board's input on study design and recruitment sites. **DISCUSSION/SIGNIFICANCE:** Translational Impact: Findings from interviews will be disseminated and evaluated by members of the community and providers. Recommendations based on our findings can be applied in mental healthcare practice to reduce identified barriers. Community dissemination can also promote the destigmatization of mental healthcare in the Somali community.

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### **"I am interested!": Lessons Learned from the All IN for Health/Indiana CTSI Health Advisory Board**

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**OBJECTIVES/GOALS:** All IN for Health's Advisory Board is an active board providing advice on strategic directions, feedback, contributing ideas, and accountability. Most recently, the HAB had 4 openings. A call to our community of over 13,000 individuals was published. We received 488 applications. We share the lessons in motivations and interests shared respondents. **METHODS/STUDY POPULATION:** Four hundred eighty-eight individuals submitted applications for participation in the All IN for Health Advisory Board. The call went out to the All IN for Health volunteer research network comprised of community members across the state. The call mentioned a nominal compensation of \$50/hour, and time commitment of a 2-hour board meetings via video conferencing every 3 months. The application process included the following questions: 1. What lived experiences and/or personal interests have motivated you to be involved in All IN for Health? 2. Please explain why you are interested in being an All IN for Health Advisory Board member? **RESULTS/ANTICIPATED RESULTS:** We organize the findings in two categories: Motivation and Interests. The motivation category refers to individual's motivation to be part of the All IN for Health initiative. Interest category referred to individual's specific interest in participating in the All IN for Health Advisory Board. Individuals were motivated to participate based on (1) family or friend diagnosis, (2) personal diagnosis, (3) roles as caregivers, (4) desire to impact change and advocacy, (5) role as health professional, and (6) previous participation in research. Interests followed similar themes with additional categories of sharing their experience, previous research and board experience, as well as a desire to educate future generations of researchers. **DISCUSSION/SIGNIFICANCE:** We share the narratives honoring individual stories for the top three motivations and interest. This information can be used for recruitment to boards, research participation, and healthcare advocacy, and highlights importance of sharing successes and challenges to the processes of forming and sustaining effective boards.

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### **Do they REALLY Trust Us?: The Importance of Trust and Trustworthiness in All IN for Health**

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**OBJECTIVES/GOALS:** The critical role that trust plays continues to be documented and highlights the gap in understanding the extent to which initiatives such as All IN for Health from the Indiana Clinical and Translational Institute (I-CTSI) can improve trust between the community and researchers. We discuss measures of trust and evaluate how we may improve recruitment. **METHODS/STUDY POPULATION:** In this study, we invited over 13000 volunteers from the All IN for Health research participant registry. Six hundred and sixty-three (663) respondents participated in the survey. The Relationship of Trust and Research Engagement Survey included three validated surveys: Distrust in Healthcare Organizations, the Trust in Medical Researchers scale by Hall et. al, and Patient Trust in Medical Researchers by Mainous et al.. The 36-item survey also included open-text questions. **RESULTS/ANTICIPATED RESULTS:** Based on preliminary results 74% agreed it's safe to be in medical research, yet 79% had never been asked to participate in medical research by their doctor. Sixty percent believed that HCOs put money above patients' needs. Forty percent agreed that doctors do medical research for selfish reasons. Fifty percent disagree that patients get the same medical treatment regardless of race/ethnicity. Moreover, 28 % agree that medical researchers act differently toward minorities. Between 9 and 11% believe that researchers select minorities for their most dangerous studies and some projects are secretly designed to expose minoritized groups to diseases. Our next step is to disaggregate the data by race and ethnicity and evaluate these answers. **DISCUSSION/SIGNIFICANCE:** This study's population willingly engaged in a research registry making their diminished trust quite alarming. Amongst the general population, trust in scientists is now below pre-pandemic levels. We must critically assess our own trustworthiness, and critically reflect on the authenticity of our efforts.

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### **Motivators and Barriers to COVID-19 vaccination among Native American and Latino Communities**

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**OBJECTIVES/GOALS:** COVID-19 disproportionately impacts rural communities of color. Socioeconomic status, occupation and chronic

illnesses lead to worse COVID-19 outcomes. This study identifies motivators and barriers of COVID-19 vaccine uptake in the Latino and Flathead Reservation agricultural communities. **METHODS/STUDY POPULATION:** Thirty key informant interviews and 6 focus groups (N=39 focus group participants) were conducted with community and tribal leaders using an interview guide informed by the Theory of Planned Behavior, Social Cognitive Theory, and the Social Contextual Factor Frameworks. The interview guide was designed to understand the motivators and barriers of COVID-19 vaccine uptake. The Community Advisory Board, community investigators and community health workers from the community reviewed and revised the guide. A codebook applied deductive coding to informant responses, followed by an inductive, constant comparison approach. Three analysts met to refine the codebook and conduct inter-rater agreement. **RESULTS/ANTICIPATED RESULTS:** Participants from Flathead reservations and Yakima frequently noted a desire to protect one's self, family and elders. This significant motivator encouraged individuals to receive the COVID-19 vaccine, despite sincere vaccine concerns and government rollout. Barriers included concerns regarding rumored, serious or rare side effects, speed of vaccine development and misinformation. Key differences exist between both communities. Yakima participants noted religious concerns and ID requirements as major barriers. Flathead reservation participants noted distrust and historical trauma of the U.S. government and issues with access (e.g. transportation, technology). **DISCUSSION/SIGNIFICANCE:** The pandemic disproportionately impacts vulnerable communities in agricultural settings. Participants in both communities felt vaccine availability had outpaced uptake. Clearly, culturally sensitive education and respectful communication would be key in addressing vaccine concerns and improving vaccine uptake.

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### Private equity acquisition of nursing homes and the impact on long stay residents and racial disparities in care outcomes

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**OBJECTIVES/GOALS:** To investigate nursing homes (NHs) acquired by private equity (PE) firms and estimate the effect of PE NH acquisitions on NH care quality for NH residents and whether PE NH acquisitions exacerbate racial inequities in quality of care. **METHODS/STUDY POPULATION:** My research estimates the causal effect of NH PE acquisitions on NH access and quality of care for NH residents and whether acquisitions exacerbate racial disparities in NH care for about 115 PE-owned NHs in the US, measuring the quality of care at the facility survey year level, and using an array of NH-level data sources. I identified 115 PE-owned NHs (treatment group) and 665 non-PE-owned NHs between 2003 and 2010, using the Online Survey Certification and Reporting database to obtain facility characteristics. I compare facility characteristics (e.g., payer mix, staffing levels, and quality measures such as pressure ulcers, unexpected weight loss, acuity, and health deficiencies). I will then test whether effects differ by race, with hypotheses informed by Public Health Critical Race Praxis approach. **RESULTS/ANTICIPATED RESULTS:** Preliminary results show that staffing levels differ between PE and non-PE-owned NHs in a way that aligns with a shift in focus toward the Medicare population i.e. short stays. We also find that deficiencies increased in PE-owned NHs compared to non-PE-owned NHs. We expect that PE acquisitions may lead to slightly widening racial disparities in NH care quality. Results may

show that PE-owned NHs have a higher share of low-rated, high-BIPOC facilities. In weak markets, PE-owned NHs may have a higher share of BIPOC residents compared to highly competitive markets. This is because PE managers may prioritize cost over quality by cutting services. However, since quality measures are self-reported, except for measures related to deficiencies, this predicted lower quality of care may not be evident in observed data. **DISCUSSION/SIGNIFICANCE:** Understanding how PE ownership impacts nursing home care quality for long-stay residents, especially those funded by Medicaid, can help develop intervention strategies to effectively mitigate racial inequities in NH care, as Medicaid funded NH residents are more likely to be Black, Indigenous, and people of color.

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### Self-Reported Race, Street Race, and Sleep Quality & Hours During the COVID-19 Pandemic Outbreak

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**OBJECTIVES/GOALS:** Our objective is to assess whether street race is a stronger predictor of sleep quality and sleep hours than self-reported race. We also seek to understand whether the association between race and sleep quality/hours can be explained by experiences of microaggressions. **METHODS/STUDY POPULATION:** This study uses data from the National Couples' Health and Time Study (NCHAT), a population-representative sample of 20–60 year-olds (N=3,642) who were married or cohabiting during 2020–2021 when the COVID-19 pandemic disproportionately negatively impacted racial and ethnic minorities in the U.S. (Boserup et al., Yip et al.). During this time, incidents of racial trauma increased (Tessler et al.). Using NCHAT data we examine whether street race is a stronger predictor of sleep quality and sleep hours than self-reported race. We also seek to understand whether the association between race and sleep quality/hours can be explained by experiences of microaggressions. **RESULTS/ANTICIPATED RESULTS:** Results show that microaggressions mediate the link between identifying as Black and being perceived as Black or Asian and sleep quality/hours. Identifying as Black and being perceived as Black or Asian, compared with non-Latinx White respondents, is associated with more frequent microaggressions. More microaggressions are associated with poorer sleep quality and fewer sleep hours. Asian street race is a marginally better predictor of microaggressions than self-reported race. In all models, microaggressions are associated with poorer sleep quality and less sleep hours. **DISCUSSION/SIGNIFICANCE:** With a growing non-white population, the wellbeing of our future generations is in everyone's best interest. Poor sleep increases the risk of cardiovascular disease, diabetes, obesity, and cancer. The United States spends \$93 billion in excess medical care costs due to health disparities.

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### Addressing Structural Racism Using Community Based System Dynamics

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**OBJECTIVES/GOALS:** 1. Describe method of Community Based System Dynamics. 2. Describe CBSD as used in addressing structural racism in a previously redlined community. 3. Review example