Facilitators and Barriers in Screening Sexually Active Female Adolescents for Chlamydia Infection in the Suburban Practice Setting

Ashaunta Tumblin Anderson1, Barbara Frankowski2, Paul J. Chung2 and Judith Shaw3
1University of Southern California; 2Kaiser Permanente School of Medicine and 3University of Vermont

OBJECTIVES/SPECIFIC AIMS: 1) Describe strategies pediatric providers perceive improve chlamydia screening of sexually active female adolescents (SA), and 2) describe barriers to regular screening of SA for chlamydia METHODS/STUDY POPULATION: Using qualitative methods, 14 general pediatric providers across 7 clinical sites in Vermont were interviewed to ascertain best practices and remaining challenges. Semi-structured interviews lasting 30-45 minutes were audiotaped and transcribed. Chlamydia screening rates provided by BCBS-VT were used to categorize participant responses across three performance tiers, data were coded, and themes identified within these tiers. RESULTS/ANTICIPATED RESULTS: Facilitators: When asked to describe facilitators of chlamydia screening, providers in the top tier of chlamydia screening emphasized the importance of adequate insurance to cover the cost of testing. Providers in the middle performance tier cited use of pre-visit questionnaires, and those in the bottom performance tier identified no best practices. Other strategies included improving physician confidence and awareness, establishing practice- and individual-level routines, and providing strong leadership and communication of local screening rates. Barriers: Across the 3 performance tiers, the most common challenges to consistent chlamydia screening were threats to patient confidentiality, cost of the screening test, and requirement for patient disclosure of sexual activity. Less commonly, providers were concerned that adolescent patients were not reliable to obtain screens off-site, or fill treatment prescriptions without the help of a parent. DISCUSSION/SIGNIFICANCE OF IMPACT: The need for systematic, confidential, and inexpensive means for screening SA for chlamydia was highlighted in both the best practices and challenges described by providers of pediatric care in the suburban practice setting. Policy and practice interventions may target these needs to improve the reproductive health of female adolescents.

Frailty Associated with Increased Rates of Acute Cellular Rejection Within 3 Months After Liver Transplantation

Laila Fozouni1, Adrienne Lebsack, Yara Mohamad, Chris Freise, Peter Stock and Jennifer Lai
1University of California, San Francisco

OBJECTIVES/SPECIFIC AIMS: There is currently a gap in the literature regarding the relationship between acute cellular rejection and frailty in LT patients. We aimed to evaluate the association between frailty and acute cellular rejection in LT patients. METHODS/STUDY POPULATION: Included were LT recipients from 2014-16 at a single center who had a frailty assessment prior to LT using the Liver Frailty index consisting of grip strength, chair stands, and balance. Frailty was defined by a Liver Frailty Index > 4.5. Data on acute cellular rejection at 3 months (primary outcome) and immunosuppression regimens were collected from medical chart review. Univariable and multivariable logistic regression assessed the associations between frailty and acute cellular rejection. RESULTS/ANTICIPATED RESULTS: A total of 241 LT recipients were included. Of these, 37% were female, 55% had Hepatitis C, and the median (IQR) age was 60 (54-65); 46 (19%) were classified as frail. 98% of patients were on a combination of mycophenolate, corticosteroids and tacrolimus on discharge compared to 80% by 3 months. Within the first 3 months post-LT, 7 (15%) of frail patients versus 10 (5%) (p = 0.02) of non-frail patients experienced acute cellular rejection. In univariable logistic regression, frailty was associated with a 3.3 times higher odds of acute cellular rejection at 3 months (95%CI 1.19, 9.26, p = 0.02); age (OR 0.91), Black race (OR 3.2), autoimmune disease (OR 2.3), and diabetes (OR 0.3) were also associated with acute cellular rejection at 3 months with a p-value<0.20. In a multivariate analysis, after adjusting for age, frailty remained significantly associated with rejection (OR 3.06, 95%CI 1.04, 9.01, p = 0.043). There were no significant differences in immunosuppression regimens or rates of mycophenolate dose reduction in the first 3 months between frail and non-frail patients. DISCUSSION/SIGNIFICANCE OF IMPACT: Frailty is associated with an increased rate of acute cellular rejection within 3 months post-LT, despite similar immunosuppression regimens and doses. Future studies should evaluate whether frailty should be considered in the management of immunosuppression in the early post-transplant period.

Group Concept Mapping of Stakeholder’s Ideas to Increase the Quantity and Quality of Clinical and Translational Research in Rhode Island

Stephen Kogut1, Jacqueline Fede, PhD, MS1, Anthony Hayward, MD PhD2 and John Stevenson, PhD1
1University of Rhode Island and 2Brown University

OBJECTIVES/SPECIFIC AIMS: We sought to solicit and synthesize stakeholders’ ideas for how the Advance-CTR program can best