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### The Impact of Minimum Volume Thresholds on Geographic Access to Stroke Thrombectomy

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**OBJECTIVES/GOALS:** At least 15 stroke thrombectomies per proceduralist per year are required for Thrombectomy-Capable and Comprehensive Stroke Centers. We sought to estimate the potential impact of these minimum volume thresholds on geographic access to stroke thrombectomy (ST). **METHODS/STUDY POPULATION:** Using the Florida State Inpatient Database, we will identify patients discharged with acute ischemic stroke from 2015-2019 and all non-federal facilities that performed ≥1 ST procedure per year. We will then calculate the proportion of stroke patients who live within 20, 65, 115, 165 and 200 miles (correlating with estimated ground transport times of 1, 2, 3, 4 and 5 hours, respectively) of centers that perform ST using ArcGIS software and evaluate the impact of varying the threshold ST volume required by each facility on this proportion. We will then perform multiple two proportion z-tests to compare proportions of patients within driving distance over time. **RESULTS/ANTICIPATED RESULTS:** We hypothesize that over time, and particularly after the pivotal trials of ST were published in 2015, that the number of facilities that perform ST have increased over time, which would increase the geographic access to ST. We also hypothesize that since the Joint Commission set the minimum procedural volume for proceduralists at Thrombectomy-Capable and Comprehensive Stroke Center to 15 per year, this would work to increase regionalization and could work to decrease geographic access to ST. However, we hope to elucidate the net impact of the interplay between these two opposing factors on regionalization of care over time which is currently unclear. **DISCUSSION/SIGNIFICANCE:** Current ST volume thresholds have focused on technical proficiency but may impact regionalization of care and geographic access to ST. Since access to ST is time-sensitive, a data-driven approach and better coordination on a regional level may be necessary to ensure timely access to ST.

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### Explaining the Transportation Dimension of Food Access

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**OBJECTIVES/GOALS:** Lack of a vehicle and the distant location of supermarkets influence the ease with which people can shop for healthy foods. The aim of this qualitative study is to understand how transportation impacts food access and food purchases of Baltimore residents who do not own an automobile. **METHODS/STUDY POPULATION:** The Lyft Grocery Access Program was piloted in Baltimore, MD from November 2019 through September 2020. Eligible households resided in Healthy Food Priority Areas, formerly known as food deserts, in south and west Baltimore and also did not own a vehicle. Enrolled households were offered discounted Lyft rides to select supermarkets. Participants for the present study will be purposively recruited via email and phone using contact information that was provided by enrolled households during the pilot program. Each in-depth interview will be conducted via Zoom and recorded, transcribed and analyzed for themes by two trained coders. Data collection and analysis will occur simultaneously. Data collection will cease once data saturation is reached and themes will be derived from the data. **RESULTS/ANTICIPATED RESULTS:**

This study is in progress. Anticipated themes may relate to the food environment, transportation and food access. **DISCUSSION/SIGNIFICANCE:** Access to healthy foods is an important determinant of health, and how food access is impacted by broader aspects of daily living such as transportation will add to the food access literature. Findings may provide new insights that can help inform food policy and transportation planning in urban communities.

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### Disparities in the Management of Low-Risk Febrile Infants: An Interim Feasibility Report

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**OBJECTIVES/GOALS:** Well-appearing febrile infants are a model for exploring communication, bias, and health disparities in the pediatric emergency department (ED). Using mixed methods, we will perform an in-depth analysis of disparities and shared decision making, a potentially modifiable driver of inequities. **METHODS/STUDY POPULATION:** We will conduct a multicenter cross-sectional chart review study of well-appearing febrile infants 29-60 days old treated in the ED and apply multivariable logistic regression to assess the association between 1) race/ethnicity and 2) limited English proficiency with the primary outcome, discharge to home without lumbar puncture and without antibiotics (standard of care). We will concurrently perform an interpretive study using purposive sampling to conduct interviews with: 1) minority parents of febrile infants and 2) ED physicians. By capturing dyadic data, we will triangulate perspectives to elucidate disparities and bias that can emerge in the shared decision making process. **RESULTS/ANTICIPATED RESULTS:** Forty member institutions of the Pediatric Emergency Medicine Collaborative Research Committee are participating, providing a projected cohort of 3000 infants. In the 6 months since site recruitment, 235 eligible infants have been entered into the dataset (43% minority race/ethnicity, 6% language other than English), 61% of whom received the primary outcome. Chart review has the benefits of 1) ensuring exclusion of ill infants, 2) providing data on interpreter use that is unavailable in administrative datasets, and 3) allowing an analysis of shared decision making. These findings will inform an interpretive study of parent and provider experiences of bias in shared decision making. **DISCUSSION/SIGNIFICANCE:** We demonstrate the feasibility of a large-scale manual chart review to analyze disparities within a shared decision making context. Partnered with qualitative scholarship, this research will support the development of communication interventions to mitigate implicit bias in the clinical encounter.

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### Self-Reported Symptoms for COVID-19 Public Health Surveillance: A Window to Social Determinants of Health

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**OBJECTIVES/GOALS:** HelpBeatCOVID19.org, a novel self-reporting symptom tracking surveillance system, is based at the University of Alabama, Birmingham. Helpbeatcovid19.org captures social determinants of health (SDOH) data. This presentation will report

research in progress to understand the utility of self-reported data with communicable disease outbreaks. **METHODS/STUDY POPULATION:** Individuals voluntarily completed an online questionnaire at HelpBeatCOVID19.org which captured SDOH data and other disease surveillance variables including zip code, gender, age group, race, ethnicity, symptoms, underlying conditions, type of home (e.g., single-family, mobile home, etc.), and household COVID-19 diagnosis status. The data are stored on HIPAA-compliant servers. De-identified self-reported data were culled from the HelpBeatCOVID19 database, cleaned, sorted, and analyzed by zip code. Using STATA/SE 16.1, we employed regression analysis to determine if there might be any statistically significant associations that could be made based on zip codes, especially where there are health disparities in historically African American neighborhoods in Jefferson County. **RESULTS/ANTICIPATED RESULTS:** To date, 102,308 people have reported their symptoms in HelpBeatCOVID19. Of those, 77,903 are from Alabama. More than half of the people who completed HelpBeatCOVID19.org reported zero symptoms. However, 19.3% of Alabamians reported having underlying health conditions. Midfield, AL, a predominantly African-American neighborhood (81.1%), has 74.1% of people reporting underlying conditions where the median household income is \$38,750. By comparison, Vestavia Hills, AL, a more affluent neighborhood with an 88.8% White population and median household income being \$109,485, had more people participating in HelpBeatCOVID19 (3,920), yet a smaller percentage (15.2%) with underlying health conditions. Final results will be reported during the ACTS Conference. **DISCUSSION/SIGNIFICANCE:** Our analysis of the data reveals that in Jefferson County, AL, a greater number of people in affluent communities participated in the study. Whereas state-wide, a greater percentage of individuals indicated that they had zero symptoms. Identifying self-reported underlying conditions that impact persons with COVID-19 symptoms will be significant.

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### Helpline Services Before, During, and After the COVID-19 Pandemic: A Time Series Analysis

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**OBJECTIVES/GOALS:** This study examined patterns in helpline call data as the COVID-19 pandemic evolved including the impact of stay-at-home orders, relaxing of restrictive orders, and stages of vaccine uptake, as well as differences in call volume by Chicago neighborhood health indicators. **METHODS/STUDY POPULATION:** From November 1, 2018 to June 30, 2021, 56 NAMI-Chicago workers accepted 26,173 helpline calls from 9,374 individuals from 438 zip codes across northeastern Illinois with the majority of calls from high poverty Chicago communities. Descriptive and time series analyses examined patterns in call volume related to the onset of the COVID-19 pandemic, Illinois Stay-at-Home Order, and Illinois reopening and vaccine uptake plan relative to comparable times the prior year. Health indicators from the Chicago Health Atlas (<https://chicagohealthatlas.org/>) were examined to determine patterns related to NAMI call volume and various health indicators at the zip code level. **RESULTS/ANTICIPATED RESULTS:** Time series analysis indicated the greatest number of calls occurred in 2020; specifically,

there was a 212% increase in call volume and 331% increase in repeat callers (three or more calls per caller) during the first and second phase (March 20th to May 28th) of Illinois Stay-at-Home Order from 2019 to 2020. Analysis of the callers primary need indicated NAMI provided resources and referrals to people with unmet basic needs such as housing, food, and access to healthcare during the height of COVID-19 Pandemic in 2020. A series of ANOVAs indicated that individuals from Chicago zip codes with high levels of uninsured rates, poverty rates, households using SNAP benefits, and economic diversity called NAMI significantly more than those with low levels of these health indicators. **DISCUSSION/SIGNIFICANCE:** Helplines are a much-needed model to assess needs and implement services during public health crises, particularly in communities experiencing economic hardship and stress. Implications for behavioral health service needs both during and following the pandemic will be discussed.

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### Implementing a Multi-Component Intervention to Reduce Hypertension Through DASH Diet Congregate Meals and Self-Measured BP (SMBP) at Two NYC Senior Centers

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**OBJECTIVES/GOALS:** To test whether implementing DASH-aligned meals in a congregate meal program, combined with Self-Measured Blood Pressure (SMBP) monitoring, lowers systolic blood pressure in community-living seniors at two senior centers. Secondary Aims included cognitive and behavioral change, and attention to client preferences. **METHODS/STUDY POPULATION:** The Carter Burden Network (CBN) provides services and congregate meals to older adults in NYC, many with low income, and unmet health needs. Eligible participants at two CBN sites, aged 60 or older and consuming >4 congregate meals/week, were recruited. After baseline assessments, participants received DASH-aligned meals onsite, education on nutrition and BP management, and personal devices and support for self-measured blood pressure (SMBP) monitoring. Primary outcome data (BP measured by health professional) was collected at Month 1, with secondary assessments at Months 3 and 6. Staff downloaded SMBP data regularly. Study surveys tracked cognitive and behavioral changes. Qualitative feedback from a project Advisory Committee, participants and study partners was collected throughout implementation. **RESULTS/ANTICIPATED RESULTS:** 97 Participants enrolled (49% White, 32% Black, 19% Other races; mean age 73). At Baseline, 67% were overweight/obese; 80% were hypertensive (32% Stage I; 48% Stage 2). Primary outcome: Mean change in systolic BP at Month 1 compared to Baseline, was -4.41 mmHg (n= 61; p=0.07). By multiple regression analysis, change in BP at Month 1 was associated with BMI, age, and baseline blood pressure (p= .02, .04, .00, respectively). SMBP: Mean change in systolic SMBP by End-of-Study was -6.9 mmHg (p=.003). 56% participants completed SMBP through Month 1 and 30% to End-of-Study. Mean frequency of