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### Examining Relationships between and Experiences of Patient and Provider Factors and Access to, Use of and Disparities in Postpartum Care: A Mixed Methods Study\*

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**OBJECTIVES/GOALS:** Alabama has the 3rd highest maternal mortality ratio in the U.S., with more than 50% of deaths occurring postpartum. There is little evidence on the prevalence or equity of postpartum care use in Alabama. This mixed methods study examines relationships between patient and provider factors and access to, use of, and racial disparities in postpartum care. **METHODS/STUDY POPULATION:** I will use a sequential explanatory mixed methods design. In the quantitative phase I will analyze an integrated electronic health record and human resource dataset to identify patient and provider factors that have a relationship with receipt of at least one postpartum visit within 12 weeks of delivery in a cross-sectional, retrospective cohort of 30,000 obstetric patients in Alabama. In the qualitative phase I will describe the postpartum experiences of obstetric patients who identify as Black or African American who received or did not receive at least one postpartum visit within 12 weeks of childbirth. In the integration phase I will draw synthesized conclusions about how the results of both phases describe predictors of and barriers and facilitators to postpartum care for Black birthing people in Alabama. **RESULTS/ANTICIPATED RESULTS:** I will identify relationships between patient factors (e.g., race, racial concordance with primary provider, insurance status, age, parity, type of delivery, Area Deprivation Index, presence of a chronic condition or severe morbidity) and patient receipt of postpartum care. I will also explore whether health care provider factors (e.g., race, racial concordance with the patient, age, gender, provider type, years of experience) predict patient receipt of postpartum care in this retrospective cohort. In the qualitative phase, I will explore the experiences and perceptions of birthing people who identify as Black or African-American that help explain the relationships between patient and provider factors and receipt of postpartum care identified in the quantitative phase. **DISCUSSION/SIGNIFICANCE:** More than 50% of maternal death occurs after childbirth. Postpartum care is critical to birthing people's survival, especially in states with high maternal mortality. This study will fill a gap in knowledge about factors that have a relationship with equitable postpartum care in Alabama.

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### Listening to and Learning from the Community: A Model for Community Engagement and Building Trust

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**OBJECTIVES/GOALS:** We have developed a community engagement model that embraces several core values: bi-directional, co-equal, co-created, inclusive, culturally centered, and trust. Our promotoras de salud and community health workers (CHWs) facilitate listening sessions to understand the most pressing health needs and concerns as perceived by the community. **METHODS/STUDY POPULATION:** Our Southern California CTSI Community Engagement team includes promotoras de salud and community health workers who are trusted individuals within our targeted

communities—Latino and Black populations in South and the Eastside of Los Angeles. Listening sessions identify the community's perceived health needs and concerns, and our team in turn delivers a workshop series that addresses those concerns. Workshops are co-developed by community members, offered in English and Spanish, and delivered both virtually and in-person in community venues. Workshop topics have included mental health, depression, anxiety in children; child development and autism; COVID-19 testing, variants, and vaccines; monkeypox; and a primer on understanding clinical research. **RESULTS/ANTICIPATED RESULTS:** In 2022, we held 49 workshops that delivered evidence-based information including how to access needed resources. We had a total of 1212 participants, 60% of whom were returning, meaning they had attended at least one prior workshop. An evaluation of the workshop program demonstrated that our promotoras de salud and community health workers are trusted by the community and that workshops are meeting community needs. 677 surveys were completed by participants, 87.5% of whom were female. 85% of respondents stated that they will use the information they learned in their daily life, and 90% said they would attend another workshop. Feedback from the evaluation will inform future workshop format and topics. **DISCUSSION/SIGNIFICANCE:** Academic-community partnerships are key to advancing health equity, especially in diverse and under-resourced communities. This is one model of community engagement, which includes promotoras de salud and CHWs that was designed to build trust, empower individuals through education, and to address the health needs as defined by the community.

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### Why are Somali refugees not utilizing mental healthcare? Identifying barriers impacting mental healthcare utilization among Somali Refugees

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**OBJECTIVES/GOALS:** We seek to describe the challenges to mental healthcare access and utilization among Somali refugees in Minnesota. The objectives of this study are 1) to characterize beliefs and attitudes about mental illness and 2) identify barriers, either personally experienced or perceived, to utilizing mental health services among Somali refugees. **METHODS/STUDY POPULATION:** Mental health challenges are of particular concern among Somali refugees, who have been found to have rates of PTSD as high as 50%. However, Somali refugees are reported to underutilize mental healthcare. We will recruit 20-25 Somali refugee women and men, who are 18 years or older and reside in the Twin Cities, to participate in one on one interviews. Participants will be asked about their perception of barriers to mental healthcare services, and their beliefs about mental illness and treatment. We will transcribe the interviews, code them, and identify key themes. A community advisory board will be directly involved in the research design, recruitment, interview instrument development, interpretation of findings, and dissemination of project materials as part of our community engagement protocol. **RESULTS/ANTICIPATED RESULTS:** When completed we expect to identify mental health beliefs and barriers to mental healthcare utilization. The long-term goal of this work is to reduce the substantial mental health morbidity among Somali

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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Indiana CTSI

**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