

project/service experiences to drawing a holistic portrait of an institution-level (and, potentially, a nation-level) translational science program.

References

- Friedman M.** *Trying Hard Is Not Good Enough: How to Produce Measurable Improvements for Customers and Communities.* Trafford, 2005.
- National Center for Advancing Translational Sciences.** *NCATS Strategic Plan* [Internet], 2016. NIH (<https://ncats.nih.gov/strategicplan>)
- Smith C, et al.** Toward a science of translational science. *Journal of Clinical and Translational Science* 2017; **1**: 253–255.
- Woolf SH.** The meaning of translational research and why it matters. *JAMA* 2008; **29**: 211–213.
- Yang, K.** *Voice of the Customer Capture and Analysis.* US: McGraw-Hill Professional, 2007.

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Enhancing outcomes for young children with behavior disorders: A model for coordinated care

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OBJECTIVES/SPECIFIC AIMS: (1) Identify current barriers to coordinated care between behavior consultation and PCIT services. (2) Identify current facilitators to coordinated care between behavior consultation and PCIT services. (3) Utilize this knowledge to create and pilot a coordinated care model that will enhance PCIT and behavior consultation service outcomes. **METHODS/STUDY POPULATION:** Objectives 1 and 2: Two focus groups consisting of 8–10 behavior consultants will be conducted to gather initial information on barriers and facilitators to coordinated care. Participants will be recruited from the state-funded behavior consultation team, to represent consultation occurring in rural and urban settings. All focus groups will be recorded and transcribed to capture questions and comments. Focus groups will be provided with an initial 10-minute overview of PCIT, including theory, prescribed strategies, and mode of intervention. A grand tour question will then be asked to elicit consultant perceptions of PCIT (e.g., “What are your thoughts on the compatibility between PCIT and behavior consultation services?”), followed by probe questions designed to elicit more detailed information about any perceived differences based on philosophical approach; differences in what is recommended in childcare settings Versus at home, etc.; and perceived barriers to coordinated care between school and outpatient services (e.g., “What factors make coordinating care with outpatient providers challenging?”). Participants will be asked about their willingness to participate in a second focus group to review materials created to enhance coordinated care, based on their feedback. **Objective 3.** Based on feedback from the focus groups and quantitative data regarding factors associated with PCIT outcomes, we will develop an enhanced childcare component(s) for eventual implementation. To confirm our approach, we will invite the members of both focus groups back for a second session, in which we provide them with the created materials and elicit their feedback. We will start with a grand tour question (e.g., “How do you think parents and teachers would react to these materials?”) and then follow-up with probe questions related to feasibility (e.g., “How do you anticipate using these tools?”), appropriateness (e.g., “How adequately do you feel these materials address concerns with coordinated care?”), and acceptability (e.g., “How likely are you to begin using these tools within your consultation?”). Both focus groups will be recorded and transcribed to capture questions and comments. **RESULTS/ANTICIPATED RESULTS:** (1) Barriers and facilitators to coordinated care will include individual (e.g., acceptability of PCIT framework) and system-level factors (e.g., ease of communication between providers). (2) There will be significant overlap in coordination between the first phase of PCIT (which focuses on positive parenting strategies) and what is prescribed by behavior consultants. (3) There will be less compatibility between the second phase of PCIT (which focuses on disciplinary strategies)

and what is prescribed by behavior consultants. (4) A coordinated care model will be rated as more feasible, appropriate, and acceptable to behavior consultants than PCIT services as currently prescribed. **DISCUSSION/SIGNIFICANCE OF IMPACT:** Childhood disruptive behaviors are among the most frequent reasons for referral to outpatient child/adolescent mental health clinics (Sukhodolsky et al., 2016). Disruptive and aggressive behaviors are problematic, not only for victims of children who are aggressive but also for aggressive children as they age. Although effective treatments exist, families are often provided with conflicting strategies for behavior management by outpatient clinicians and behavior consultants in the daycare setting, thus providing children inconsistent feedback which will delay their attainment of new skills. These data will provide the initial foundation for the development of a coordinated care model that promotes treatment efficacy by improving the compatibility between clinic-based PCIT and daycare-based behavior consultation services.

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Environmental barriers and facilitators of health care access and utilization for elderly stroke survivors

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OBJECTIVES/SPECIFIC AIMS: This study will use face-to-face interviewers with Medicare-eligible stroke survivors, and adult caregivers of stroke survivors, to extend the aims of a quantitative study on healthcare utilization in elderly stroke survivors. The objective of this research is to better understand, in more detail, relevant barriers and facilitators to accessing healthcare among older stroke survivors. The ultimate goal of this research is to develop strategies to improve access to healthcare, such as home modifications; changes to the neighborhood physical environment; or interventions at the provider/service level. This research will also serve as a precursor for future intervention work that will be proposed as a part of a K01 proposal. **METHODS/STUDY POPULATION:** Participants were recruited from Ann Arbor and Flint, MI using an existing academic-community partnership as well as through the University of Michigan Stroke Clinic. A total of 8–10 stroke survivors and 1–2 caregivers were recruited through the partnership and clinic records, as well as some use of snowball sampling to obtain a socially, economically, and racially representative sample. Participants must be 65+ years old, eligible for Medicare, living in the community, identify as either White or Black, and have no major cognitive/language deficits that jeopardize informed consent. Face-to-face interviews were conducted, and open-ended questions emphasized environmental barriers and facilitators to accessing healthcare, with a focus on social and physical barriers in the home and neighborhood. Interviews were audio recorded and transcribed, and field notes from 1 to 2 sources were also documented and will be used to triangulate the data and increase coding validity. Audio recordings will be reviewed multiple times and quotes relevant to the research questions and underlying theoretical framework will be transcribed verbatim. The transcripts will be analyzed using thematic coding based on literature and the study objectives and hypotheses. I will identify primary themes related to environmental barriers and facilitators to accessing healthcare among the stroke-survivors. **RESULTS/ANTICIPATED RESULTS:** Preliminary results suggest that participants are primarily concerned about the social environment. Several interviews revealed that stroke survivors felt socially isolated and were often hesitant to ask for help because they did not want to be a burden on their family and friends. Transportation to appointments was also identified as a barrier due to the fact that many people are no longer able to drive, yet are not comfortable navigating other forms of transportation. We expect to identify additional physical and social environmental challenges to both health care utilization and well-being more generally, among older stroke survivors. Anticipated themes may include: barriers in the physical environment such as transportation to care and services, social support and social environmental factors to support feeling safe leaving home to access care. **DISCUSSION/SIGNIFICANCE OF IMPACT:** Despite the physical and economic burden of stroke, and attempts to improve outcomes for stroke survivors living in the community, stroke survivors have high rates of disability and unmet medical and psychological needs. The results from this research are anticipated to directly inform future partnerships and intervention in these, or in similar communities. Understanding how the environment influences access to healthcare for elderly stroke survivors is essential if we want to increase recommended preventative care and treatment in this vulnerable population with unique healthcare needs. The results of this study will be used to directly inform the aims and methods for other translational research projects, including a K01 proposal, in which I will develop and pilot a community-based intervention to ameliorate environmental barriers and enhance facilitators of access to healthcare for older, disabled adults.