(21%) and showed higher systolic and diastolic blood pressure, blood glucose levels, hemoglobin A1c, total cholesterol, and triglycerides levels compared with normal-weight adolescent females ($p < 0.05$). There was a statistically significant association between the BMI status of mothers and infants' birth weight, with underweight/normal-weight mothers having more low birth weight (LBW) babies and overweight/obese mothers having more large babies. The odds of having a LBW baby was 0.61 (95% CI: 0.41, 0.89) lower in obese compared with normal-weight adolescent mothers. The risk of having a preterm birth before 37 weeks was found to be neutral in obese compared to normal-weight adolescent mothers (OR = 0.81, 95% CI: 0.53, 1.25). Preliminary associations are similar to those reported in the published literature. DISCUSSION/SIGNIFICANCE OF IMPACT: This EHR database uses available measures from routine clinical care as a "rapid assay" to explore potential associations, and may be more useful to detect the presence and direction of associations than the magnitude of effects. This partnership has engaged community clinicians, laboratory and clinical investigators, and funders in study design and analysis, as demonstrated by the collaborative development and testing of hypotheses relevant to service delivery.

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Collective capacity building tool (CCBT): A unique instrument and process supporting community-campus partnerships for translation

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OBJECTIVES/SPECIFIC AIMS: (1) Provide an innovative tool used to accelerate and evaluate T3-T4 research; (2) describe the collective capacity building tool (CCBT) methodology—both programmatic and evaluative applications; and (3) share insights about the process and outcomes of community-engaged research. METHODS/STUDY POPULATION: Academic and community-based partners complete the assessment together at the beginning and conclusion of their Community Engagement pilot projects. Further, they are encouraged to use the tool and the associated insights/priorities that emerge as the basis for data-driven coaching with Community Research Liaisons throughout the 12-month grant cycle. RESULTS/ANTICIPATED RESULTS: Pre/post results with 4 cohorts of pilot grantees consistently demonstrated the most positive change in relation to 1 item: overcoming previously identified barriers to community engagement (eg, language, mistrust, scheduling conflicts). Other key findings: (1) networks of reciprocal ties expand, providing structures to support dissemination of information and interventions. (2) Partners leverage expanded networks to pursue follow-on funding and extend the scope/reach of their efforts geographically and/or with new populations. (3) Projects enhance trust in the research process by developing group processes that facilitate the respectful sharing of diverse (often alternative) viewpoints and through culturally-responsive project implementation. DISCUSSION/SIGNIFICANCE OF IMPACT: The CCBT can be used at multiple points in time to help project partners achieve the deliberate integration of CBPR principles in practice and advance community-engaged translational research efforts for sustainability and scalability. The CCBT is sensitive enough to document the iterative nature of partnership development and CBPR. An example: a great deal of variability was found in how formally partners defined roles. Further, partner roles often changed as projects evolved. Still, results indicated a general trend toward achieving greater clarity in partner roles over time. Further, the tool captured set-backs due to partner turn-over and partnerships regaining momentum after new staff came on board. Results have strong face validity: more mature partnerships reported stronger community connections and previous successes to build upon. Perhaps most importantly: the tool and associated process was well-received by academic and community-based partners alike.

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The SDM learning loop model

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OBJECTIVES/SPECIFIC AIMS: (1) To propose an iterative decision-making model of care planning for CSHCN. (2) To identify targets warranting measurement in future studies of SDM in care planning for CSHCN. METHODS/STUDY POPULATION: Conceptual model developed by a multi-disciplinary team iteratively considering the complex relationships among diverse factors affecting care planning for CSHCN, informed by clinical and implementation science experience and a scoping literature review of medical and cognitive sciences literature addressing interpersonal decision-making, communication, negotiation, and trust among children, their parents, and their clinicians. RESULTS/ANTICIPATED RESULTS: Decision-making interventions in pediatrics tend to focus narrowly on single acute decisions, providing minimal guidance for decisions related to chronic disease management over time. Few models account for the role of the child in the decision-making process, despite their ongoing development. Therefore, we propose a model of shared decision-making in the context of managing chronic illness in children that recognizes all actors and can support both the design of clinical care and research. This model —The SDM Learning Loop Model—highlights the dynamic iterative nature of exchanges between and among the clinical team and the parent-child dyad and recognizes the child as the center of each decision-making cycle. The model accounts for key practice, family, experiential, and emotional contexts influencing the decision-making encounter. In this model, change in child health status and developmental capacity resulting from a given cycle's care plan will directly influence the relationship between clinician and parent-child dyad (eg, mutual trust, attunement) and impact each party's engagement in the next round of decision-making. The relationship between experience and outcome stimulates learning. DISCUSSION/SIGNIFICANCE OF IMPACT: Our proposed SDM Learning Loop Model suggests that increasing the shared nature of decision making is not only likely to optimize care planning, but creates "buy-in" that can both reinforce the impact of positive outcomes, and moderate the negative impact on relationships when the outcome is other than desired. We hypothesize that this model can guide care planning and shape research to the benefit of both clinical outcomes and clinician-family relationships. Future work should focus on the development and validation of measures to account for the experiential and emotional contexts in which such decisions are made, and the outcomes of care in this population.

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Screening for diabetes in high-risk women: Building the data infrastructure to study postpartum diabetes screening among low-income women with gestational diabetes

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OBJECTIVES/SPECIFIC AIMS: Women with GDM have a 7-fold higher risk of developing T2DM, and rates of GDM are higher among racial and ethnic minorities and women of lower socio-economic status. There are no data on postpartum diabetes screening after the first postpartum year or among women receiving care in FQHCs. We aim to address this gap in the literature by (1) defining the rates of follow-up screening for T2DM at 6–12 weeks and 1–3 years postpartum and (2) characterizing patient, provider, and healthcare system attributes that are associated with lack of follow-up screening for T2DM in a population of low-income women with GDM. METHODS/STUDY POPULATION: This is a retrospective cohort study of women with GDM during pregnancy receiving care in Missouri FQHCs from 2010 to 2015. Electronic health records (EHR) data from 26 FQHCs is housed in a central repository through the Missouri Primary Care Association (MPCA). This includes patient demographic, lab, and medication information as well as encounter level patient and provider data for the prenatal and postpartum period. EHR data does not include accurate delivery information, however. Pregnancies during the study time frame were identified using CPT and ICD9/10 codes. Deidentified data on individuals with a pregnancy was utilized to identify a subpopulation of "GDM candidates," using a broad definition of glucose abnormalities as follows: ICD-9/ICD-10 codes for diabetes, medications and testing supplies used for diabetes, infant birth weight ≥4000 g or 8 lb or 13 oz, or abnormal glucose labs [defined as fasting glucose ≥ 95, gestational glucose screen ≥ 130, 1 h test ≥ 130 (or ≥180 if 2 h test and 3 h test recorded on same day), 2 h test ≥ 155, 3 h test ≥ 140, A1C ≥ 6, any glucose ≥ 130, or any positive urine glucose]. This subpopulation was then linked to Medicaid administrative claims data [housed at the University of Missouri Office of Social and Economic Development Analysis (OSEDA)], providing detailed information on delivery, to further characterize patients with GDM in the time frame and provide all dates necessary to classify pregnancy and postpartum periods. RESULTS/ANTICIPATED RESULTS: From the de-identified pregnancy data set including 45,810 individuals, we identified 8008 "GDM candidates." EHR data were linked to Medicaid claims data for these individuals from 2010 to 2015. Utilizing the enhanced data set, we are defining a pregnancy for each individual by the delivery date in the Medicaid record and an algorithm using lab and ultrasound record dates to define gestational age at delivery. This will result in a pregnancy level data set linked with individual encrypted identifiers with each record representing 1 pregnancy and postpartum period. GDM in pregnancy will be

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