potential advantages of digitized clinical research are still to be tested empirically and confirmed independently. Ethical analyses of DCT are particularly scant, which points to a gap in the current understanding of the ethical and regulatory implications of DCT and the issues they raise. Our research used the method of ethical analysis to examine the ethical challenges and to consider possible solutions. RESULTS/ANTICIPATED RESULTS: We identify the following ethical challenges of DCT: (1) challenges related to modifications of research protocols to allow for decentralized activities; (2) lack of expertise for ethical review and approval of digital tools; (3) different regulatory standards of privacy for clinical trials and for commercial digital tools, (4) risks to participants privacy and confidentiality involving both data and physical privacy; (5) the impact of the digital divide on DCT, (6) technology-related subject selection bias and marginalization of vulnerable groups, (7) imposing new burdens on research subjects and caregivers due to technology needs and smaller research teams, (8) restricted access to the study team, and (9) impact of digital technology on informed consent and participant understanding. DISCUSSION/SIGNIFICANCE: DCT became the primary form of clinical research during the COVID-19 pandemic. DCT rely on a wide range of internet-based tools for recruitment, informed consent, data collection, health monitoring, and communication with participants. The tools pose ethical and regulatory challenges, which should be addressed to ensure participant well-being.

Research Management, Operations, and Administration

192

Health Equity Starts with Us: Recommendations from the Indiana Clinical and Translational Sciences Institute Racial Justice and Health Equity Task Force

Sylk Sotto-Santiago[1], Brownsyne Tucker Edmonds[1], Sarah Wiehe[1] and Sharon Moe[1]
[1]Indiana Clinical and Translational Sciences Institute

OBJECTIVES/GOALS: The Indiana CTSI Strategy Committee charged the Racial Justice and Health Equity Taskforce to identify priorities with short-term and long-term goals consistent with the I-CTSI mission. In addition, I-CTSI leadership asked for a general description of current state and the resources necessary to achieve the proposed goals. METHODS/STUDY POPULATION: The Taskforce applied an inclusive excellence model to the way we look at the I-CTSI structure, policies, and programs while performing an environmental scan within and across I-CTSI partner institutions. In order to reach equitable solutions and consensus, listening tours were held with partner stakeholders guided by the SOAR framework for strategic planning. This approach allowed us to assess current resources, needs, and gaps across the system, along with a baseline of measures currently monitored. Taskforce members openly discussed strengths and opportunities for enhancement of current programs and services. In addition, these conversations offered an opportunity to disrupt existing practices and through collective agency we identified priority areas that promote equity, diversity and inclusion. RESULTS/ANTICIPATED RESULTS: The Taskforce identified recurring themes in conversations with all partners, which led to the formation of three working groups

that examined recruitment broadly: workforce, staffing, and research participation; professional development across all stakeholders from community members to I-CTSI staff; and data-centered metrics informing current state, decision-making, and accountability. Recommendations included these priorities, content, and implementation strategies. The Taskforce delivered a report to the I-CTSI leadership fostering the promotion of diversity, equity and inclusion along with a systematic collection of gender, race, and ethnicity data for individuals utilizing I-CTSI services and resources requiring additional metrics and tracking. DISCUSSION/SIGNIFICANCE: The pandemic shed light on the manner in which marginalized groups are rendered particularly vulnerable to death and disease by systemic and structural racism. The I-CTSI recognized that we cannot advance population health without attending to root causes of inequity and that includes our internal structure. We offer a potential model for other CTSAs.

Team Science

193

A CTS Team Approach to Incorporating Black Womens Conceptualization of Trust in the development of a Mindfulness Practice tool tailored for the Reproductive Provider Space

Karen Awura-Adjoa Ronke Coker[1] and Co-Author and Co-Presenter Tyler Scott Nesbit[1]
[1]University of Florida

OBJECTIVES/GOALS: The goals of the proposed project are to 1) identify the critical components of trust required by Black Women to build a visible expression of trust within their reproductive health space, and 2) incorporate the elements of trust identified into a mindfulness-based communication tool, for reproductive health care providers. METHODS/STUDY POPULATION: We will be applying a mixed-methods approach inclusive of questionnaires and focus groups. Aim 1: Our study population consists of persons who identify as 18+ Black Women in Alachua County, Florida. Aim 2: Our Population within the reproductive health space (e.g., ob-gyn, midwives, nurse practitioners, etc . . .) at the University of Florida Shands Hospital. RESULTS/ANTICIPATED RESULTS: We anticipate that our results will fully engage with our Black Women in dialogues about key components of trust they want to experience and have within their reproductive space. This will inform the development of the mindfulness-based tool which will be incorporated with continuous insights with our Black Women. The proposed research project will contribute to the call for health equity. We aim to address this barrier by recognizing the agency of Black women to conceptualize trust on their terms, which we then would incorporate into applied trainings of reproductive health providers to establish trust. Health equity will take a considerable amount of social change at many levels and this study aims to better understand the process. DISCUSSION/SIGNIFICANCE: Structural racism and health disparities are linked with the disproportionate loss of Black women and associated negative birth outcomes. Our work will provide needed insights regarding mistrust in patient-provider relationships. Inform the development of a feasible tool challenging implicit bias in health provider spaces.