

respondents is warranted in assessing patient satisfaction across providers. **Methods:** We used 2011-12 patient satisfaction data from a large ambulatory care organization (116,516 surveys for 1,022 providers). Surveys were mailed to patients after randomly selected clinic visits. Using the scoring scheme used by survey organization, answers to each question (on a 5-point Likert scale) were converted to a 0-100 scale. The overall score for each visit was an average of 6 section scores: Access, Moving through the visit, Nurse/assistant, Care provider, Personal issues, and Overall assessment. The overall visit score was aggregated at provider, clinic and region levels. We focus on overall and section scores across 4 regions of the organization. **Results:** R/E differences were substantial, from 90.7 (NHW) to 85.2 (Asian). Regional scores ranged from 88.2 (region A) to 90.1 (region D). The ranking was not consistent, however, within R/E groups; Region A scored highest among Latino and 2nd among NHW patients, while region D scored lowest among Latino and 3rd among NHW patients. True differential treatment by R/E should be most apparent in "Care provider" and "Personal issues", and less so in "Access" and "Moving through the visit". In fact, the R/E difference (NHW vs. Asian) was smallest for "Care provider" (4.3) and largest for "Moving through the visit" (7.0) scores. R/E differences were much less pronounced if the top 2 Likert categories were combined. **Conclusions:** Patient satisfaction ratings are influenced by patient R/E in that similar experiences may not be rated equally. When R/E composition varies across providers or regions, scores need to be adjusted to account for this effect or scales less sensitive to differential 'top box' scoring may be appropriate.

Keywords: Patient satisfaction; Cultural difference

doi:10.3121/cmr.2014.1250.d3-3

D3-4:

The Intersection of Ageism and Heterosexism: LGBT Older Adults' Perspectives on Aging-in-Place

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Background/Aims: Successful aging in place models promote independence, include older adults in decision-making, create an environment of personal and physical safety, facilitate social support, and provide services to enhance the health and quality of life of older adults within the communities in which they live. The applicability of aging in place models for disenfranchised groups is an important consideration. The current study, undertaken as part of a larger community-research partnership, examined the adequacy of this approach with older LGBT adults in a metropolitan neighborhood. **Methods:** This qualitative study used focus groups (n = 14), interviews (n = 29), and a town hall (n = 30) to assess barriers and supports for LGBT persons to age in place. **Results:** Most of the 73 participants identified as lesbian or gay, were aged 50-69, and lived with a partner. Discrimination and dual stigmatization (ageism plus heterosexism) emerged as cross-cutting themes that negatively impacted the aging in place categories of healthcare, housing, social support, home assistance and legal services. Establishing welcoming social spaces, disseminating knowledge resources, and promoting self-advocacy were suggested solutions. **Conclusions:** This study provides a unique contribution to knowledge about the needs of LGBT older adults pertaining to aging in place. While resilience and coping skills developed at younger ages during the "coming out" process can continue to be leveraged in later years, LGBT seniors who are less "out" are likely particularly vulnerable to the challenges presented by the intersection of ageism and heterosexism. This research offers recommendations for tailoring current aging in place models to better suit the needs of LGBT older adults.

Keywords: Aging in place; Community-research partnership

doi:10.3121/cmr.2014.1250.d3-4

D3-5:

The Role of Community Engagement in Increasing Translational Health Research Participation by Hispanics in the WWAMI Region

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Background/Aims: Increasingly, community engagement is used to increase the participation by minority communities in health research and to address health disparities. The CDC defines community engagement as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people". The goal of the Institute for Translational Health Science's (ITHS) Hispanic Community Outreach Program (HCOP) is to increase participation by Hispanics in translational health research conducted by ITHS in the WWAMI region (Washington, Wyoming, Alaska, Montana, Idaho). **Methods:** The HCOP has conducted outreach to investigators, community-based organizations (CBOs) and clinics serve Hispanics in the WWAMI region since August 2012. The HCOP's outreach activities have included phone calls, site visits, and participation in community events and conferences, resulting in a growing network of potential research partners. This network has evolved over time through personal contacts and referrals, reflecting the importance of interpersonal relationships and trust when engaging communities. To track its work, the HCOP maintains a database with the following elements: name, address, phone, email, agency affiliation and department, title, degrees, region, and level of engagement (LOE). The LOE is scored on a graded scale of 1-5 where 1 indicates a minimal LOE and 5 indicates a high LOE. **Results:** To date, the HCOP has made contact with over 840 stakeholders of whom 42% were investigators; 54% were in CBOs; and 6% were in government health agencies. The majority of HCOP's initial contacts had LOE scores in the 1-2 level. Over time, LOE scores have increased, including one partnership that received grant funding to disseminate a diabetes self-management program in Spanish. The HCOP was also awarded a NIH small conference grant for a regional conference on Latino health. In addition, the HCOP has awarded pilot funding for community engaged research. **Conclusions:** Community engagement appears to be an effective strategy for increasing the participation of Hispanics in translational health research. More research is needed to develop tools and methods for assessing the effectiveness of community engagement and its impacts on the health of communities.

Keywords: Community engagement; Hispanic

doi:10.3121/cmr.2014.1250.d3-5

PS1-41:

Racial Disparities in Congestive Heart Failure: Age, Site of Care, and 30-day Readmission

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Background/Aims: Racial disparities of 30-day readmission rates have been found in Medicare beneficiaries with congestive heart failure (CHF); however, racial disparities in the younger age groups remained unknown. Further, the association between patient demographics, site of care and 30-day readmissions are understudied. Our study aims to identify racial disparities in CHF patients across age groups, site of care and 30-day readmission rate, and to explore potential contributing variables to the racial disparity in CHF. **Methods:** This study used the 2009 Florida State Healthcare Cost and Utilization Project State Inpatient Databases (HCUP-SID). Patients 18 years or older, hospitalized with a primary diagnosis of CHF were included in this study. Multi-level modeling examined if racial disparities in risk-adjusted 30-day readmission rate could be explained by patients' characteristics (age, gender, insurance, household income, rurality, length of stay, discharge status) and hospital characteristics (whether the site of care was a minority-serving hospital at their initial admission, defined as the top 10% of hospitals who served the highest proportion of non-white patients). **Results:** Racial disparities existed in CHF patients' age at discharge, site of care, and risk-adjusted 30-day readmission rate. African American CHF patients as a group were hospitalized on average 14 years younger than Whites, and 10 years younger than Hispanics (AA: 63 vs. White: 77 vs. Hispanics: 73, $P < 0.001$). Overall, Hispanic patients had the highest readmission rate (Hispanics: 27.7%, AA: 25.9%, White: 24%). Higher readmission rates were associated with race of minority, Medicare and Medicaid program enrollment, lower income, discharge status, minority-serving hospital, and younger age (age < 55: 29%, age 55-64: 27%, age 65-74: 25%, age 75-84: 24%, age > 84: 22%. $P < 0.001$). This age trend remained in