IS YOUR COMMUNITY-BASED HEALTH PROMOTION PROGRAM EVIDENCE BASED AND READY FOR DISSEMINATION? HERE’S HOW TO FIND OUT
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Evidence-based programs (EBPs) offer proven ways to promote health and prevent disease among older adults in their communities. EBPs are based on rigorous study of the effects of specific interventions or model programs, demonstrate consistently positive changes in important health-related and functional measures, and have tools in place to maintain program access, quality, and efficiency across diverse settings. The University of North Carolina at Chapel Hill’s Center for Health Promotion and Disease Prevention (UNC HPDP), in partnership with the Evidence-Based Leadership Collaborative (EBLC), has established a review process and Review Council to identify new community programs that meet the evidence-based program criteria established by the Administration for Community Living (ACL), one of the chief U.S. federal agencies responsible for aging programs. Approved programs are then eligible for Older Americans Act Title III-D and other discretionary funding to support organizations that deliver EBPs to improve older adult health. The review process assesses the effectiveness, outcomes, and evaluation of the program, information about program implementation, training, and other key elements for successful program dissemination. The Review Council consists of national leaders with expertise in program research, evaluation, and implementation. The review process is supported by the ACL-funded National Chronic Disease Self-Management Education and Falls Prevention Resource Centers. This session will describe the ACL evidence-based health promotion program criteria that must be met for approval; an overview of the review process; and how researchers can submit their programs for review. Time will be allowed for questions, discussion, and research to practice implications.

SESSION 815 (POSTER)

AGEISM

AGEISM IN HEALTH CARE: 72 IS NOT A DIAGNOSIS
Phyllis A. Greenberg,1 and Tarynn Johnson1, 1. St. Cloud State University, St. Cloud, Minnesota, United States
This poster examines what value, if any, there is in using age as a predictor or impetus for testing, examining and diagnosing older adults. In a cross sectional survey (Davis et al. (2011) used the Expectations Regarding Aging Scale to assess primary care clinicians perceptions of aging in the domains of physical/mental health and cognitive functioning. Sixty-four percent of respondents agreed with the statement “Having more aches and pains is an accepted part of aging while 61% agreed that the “Human body is like a car when it gets old it gets worn out. And 51% agreed that one should expect to become more forgetful with age while 17% agreed that mental slowness is impossible to escape. How might these attitudes and biases effect how older adults are diagnosed, heard, spoken to, and treated (medical treatment as well as patient/professional interaction)? Are older patients/clients underserved or over served? Is forgetting where you put your keys always or even usually a sign of dementia? How helpful then is the use of age and are there other factors that should and can take precedence? What do we know and what don’t we know if we know someone’s age? Successful and innovative tools are explored that acknowledge age biases and strategies are presented to change age biases in education, training and practice.

PERCEPTIONS OF PERPETRATORS OF AGEISM
Alison L. Chasteen,1 Michelle Horhota,2 and Jessica Crumley-Branyon2, 1. University of Toronto, Toronto, Canada, 2. Furman University, Greenville, South Carolina, United States
What are the consequences for perpetrators who engage in different types of ageism? We compared young (n=316), middle-aged (n=464), and older adults’ (n=273) perceptions of a perpetrator who engaged in an ageist action. Participants read a vignette about a pedestrian (the perpetrator) offering unwanted help to an older woman crossing the street. We manipulated the ageism type (benevolent or hostile), the reaction of the older target (acceptance, moderate confrontation or strong confrontation) and assessed the overall impression of the perpetrator. Main effects emerged for Ageism Type and Age Group. Overall, participants rated the perpetrator more positively in the benevolent condition compared to the hostile condition. Middle-aged and older adults rated the perpetrator more positively than young adults did. A Time x Confront interaction suggested that the perpetrator’s overall impression was not impacted when the target of the ageist act accepted the action or moderately confronted the perpetrator. In contrast, when the target confronted the perpetrator strongly, the overall impression of the perpetrator decreased. An Ageism Type x Age Group x Time interaction on overall impression also emerged. There were no age differences when the perpetrator committed a hostile act of ageism. In contrast, in the benevolent condition young and older adults perceived the perpetrator more negatively after the target’s reaction, whereas middle-aged adults did not adjust their impression. Taken together, these results suggest that young and older adults may be less accepting of benevolent ageism compared to middle-aged adults.

PERCEPTIONS OF INDIVIDUALS WHO CONFRONT AGEISM
Michelle Horhota,1 Alison L. Chasteen,2 and Jessica Crumley-Branyon2, 1. University of Toronto, Toronto, Canada, 2. Furman University, Greenville, South Carolina, United States
What are the consequences for older adults who confront ageism? We compared young (n=316), middle-aged (n=464), and older adults’ (n=273) perceptions of an older target who confronts the perpetrator of an ageist action. Participants read a vignette about a pedestrian offering unwanted help to an older woman crossing the street. We manipulated the type of ageism (benevolent or hostile), the reaction of the older target (acceptance, moderate confrontation or strong confrontation)