

While considerable research has targeted gait, balance and preventing falls in individuals with Parkinson's disease (PD), less is known about the ability to rise from the floor in this population. The aims of this study were to 1) Examine the relationship between locomotion and physical performance tests and the timed supine to stand performance measure and to 2) Identify both the time required and predominant motor patterns utilized by persons with PD to complete to floor rise transition. A cross-sectional design was utilized. Twenty community-dwelling older adults with PD (mean age 74.8 \pm 9.5 years; 13 men) performed a standardized floor rise test and locomotion tests in a structured task circuit. Subject demographic and anthropometric data were also collected. Statistical analyses included descriptive statistics and Pearson Product Moment correlations. Fifteen subjects (75%) demonstrated the crouch kneel pattern and fourteen (70%) used an all-4's strategy to rise to stand. The mean time to rise from the floor was 14.9 (\pm 7.6) seconds and slower than published norms for persons without PD. Nine subjects required the use of a chair to perform floor recovery. Supine to stand performance time was significantly correlated with the: Dynamic Gait Index ($r = -0.66$; $p < 0.002$), Five Times Sit to Stand Test ($r = 0.78$; $p < 0.001$), Timed Up and Go Test ($r = 0.74$; $p < 0.001$), and gait velocity ($r = -0.77$; $p < 0.001$). Rising from the floor demonstrates concurrent validity with locomotion and physical performance tests. Floor recovery techniques can be incorporated in fall prevention initiatives in conjunction with PD symptom management.

ACHIEVING THE TRIPLE AIM THROUGH A FALLS PREVENTION INNOVATION IN LONG-TERM CARE

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Falls disproportionately burden frail older adults in long-term care, which is evidenced by the 60% fall rate annually in this setting. Our health systems improvement model, framed by the Health Outcomes Model for falls prevention, is targeted to achieve the triple aim of better health, better care, and better value. Highlighting evidence from three inter-related studies, this presentation describes the impact of a practice change model and its impact on patient, unit/staff, and organizational level factors as related to facility-wide falls prevention. In study one, we used an evidenced-based practice approach and assessment tool to achieve total and recurrent falls reduction over one year by 32% and 25%, respectively ($p < 0.001$). In study two, the annual savings of using this approach was assessed and showed a total savings of \$53,531.00, which equates to \$700.00 per falling person. In pilot study three, a convenience sample of 15 older adults who were interviewed about their fall by nurses using this approach stated they felt valued and that the nurse cared about their story ($n = 6$; 40%). Purposive efforts to embed the model and effective strategies for adoption and implementation are presented.

PATTERNS OF DISABILITY ACCORDING TO ENROLLMENT TO HEALTH INSTITUTIONS AMONG ADULTS AGE 50 AND OLDER IN MEXICO

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The aim is to describe and analyze the progression of the limitation in the Basic Activities of Daily Living (ADL) in the period 2012 - 2015, in adults over 50, grouped by their enrollment to public health services and private health institutions in Mexico (6 groups). The sociodemographic and health characteristics of each set of adults are included in this study. Disability is measured using the ADL scale. Data come from the longitudinal Mexican Health and Aging Study in the years 2012 and 2015. Multinomial logistic regressions and multi-state life tables were carried out for the analysis. Between 35% and 50% of the participants with disabilities at the beginning of the study, recovered their functionality regardless of which health institution they were enrolled to. Those individuals enrolled in two or more institutions are .33 times more likely to have no disability, compared to those who are not enrolled in any institution. Transition probabilities from active life to ADL disability rise sharply with age until 86 years old (21%), from which it begins to descend. Conditional life expectancy estimates for those initially healthy at the age 60 is 30.07 years. Of the above, 4.74 years are lived with disabilities. The disability process follows different trajectories in each group of enrollees. These trajectories were associated with socioeconomic and health factors (age, sex, diabetes and cognition). Being enrolled in 2 or more institutions is related to the prevention of disability. This is probably due to the increased access to health services.

NOVEL INSIGHTS ON THE RELATIVE IMPORTANCE OF CLINICAL AND GAIT MEASURES FOR DETECTING FALL RISK IN OLDER ADULTS

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We sought to extend recent research that explored model-based approaches for combining clinical and gait measures to determine the most sensitive grouping for retrospectively classifying fallers from non-fallers which resulted in a model with 92% sensitivity and 66% specificity and an overall model of 83%. In the present study, the clinical assessment battery was augmented by incorporating more challenging balance items while removing clinical measures characterized by ceiling effects and restricted range. Thirty-two community-dwelling older adults (>70yrs, 16 fallers, 16 non-fallers) completed a battery comprising 76 measures of more challenging clinical measures of mobility and balance, and retained gait (GaitRITE), postural sway and physiological measures. Within each domain, highly collinear and theoretically-redundant measures were removed. Next, a Principal Component Analysis (PCA) identified those clinical and gait variables that accounted for the most unique variance. Finally, a backward stepwise logistic regression was performed on the reduced set of variables from the PCA to develop predictive equations. The current analysis yielded improved specificity of 75%, but slightly lower sensitivity 81%.