

Academy of Geriatric Physical Therapy

Essential Competencies in the Care of Older Adults at the Completion of a Physical Therapist Postprofessional Program of Study



Essential Competencies in the Care of Older Adults

Preface

As the profession of physical therapy matures and evolves, highly skilled clinical specialists are required to efficiently manage movement dysfunction in older adults. The need for more highly skilled geriatric clinical specialists has been well established.¹ Residency programs in geriatric physical therapy is the most formal way to train physical therapists postprofessionally.² While there are certainly attributes and behaviors all postprofessional residency graduates should possess, regardless of the area of specialty practice, there are competencies associated only with geriatric physical therapy. Furthermore, while the Description of Specialty Practice: Geriatrics (DSP) describes broad content areas frequently associated with geriatric specialty practice based on survey data,³ there is a need for specific competencies that should be expected of all postprofessional program graduates based on best evidence, evolving models of practice, and emerging areas of practice regardless of the frequency of their clinical application. The American Board of Physical Therapy Residency and Fellowship Education (ABPTRFE) is in the process of developing a document to assess core competencies across all areas of specialty practice.² Thus, the purpose of this document is to identify the knowledge, skills, and behaviors essential of a graduate of a postprofessional program of study in geriatric physical therapy. This document's intended primary use is as a curricular guide for geriatric residency programs. It has the potential to be adapted into resident assessment tools (with proper validation). This document is not intended to serve as a tool for preparation for the American Board of Physical Therapy Specialties (ABPTS) Geriatric Clinical Specialist (GCS) examination since the competencies contained within this document do not directly align with the Description of Specialty Practice for Geriatrics, from which the GCS examination is based. However, individuals preparing for the GCS examination may also find this document a helpful supplement.

History of the Essential Competency Documents

The document 'Essential Competencies in the care of Older Adults at the Completion of the Entry-level Physical Therapist Professional Program of Study' combined two documents.⁴ Its six main Domains and the bolded and lettered Competency Statements were taken directly from the 'parent' document 'Multidisciplinary competencies in the care of older adults at the completion of the entry-level health professional degree'.⁵ This parent document was developed by a multidisciplinary group (including physical therapists) and is endorsed by over 25 professional organizations including the American Physical Therapy Association (APTA) and the Academy of Geriatric Physical Therapy (AGPT).

In 2011, the AGPT formed a taskforce to develop the essential competencies at entrance to the profession, using the Multidisciplinary Competencies⁵ as the framework. That taskforce identified sub-competencies that provide specificity and detail about the knowledge, skills, and behaviors these overarching competencies translate into for physical therapist at entry to the profession. Similarly, this document built upon the entry-level competencies by adding, eliminating, and revising wording as necessary. The current Taskforce found it necessary to revise both the primary competency statements and the sub-competencies listed under each heading. Thus, the result is not intended to be an expansion of the Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree⁵ or the Essential Competencies in the Care of Older Adults at the Completion of the Entry-level Physical Therapist Professional Program of Study,⁴ but rather a stand-alone document for physical therapists at the completion of a postprofessional program of study.

It is often hard to capture just what makes the graduate of a postprofessional specialty training program different from an entry-level generalist through a list of competencies. The description of knowledge, skills, and behaviors at entry-level often seem very similar to those of the advanced practitioner. The difference often revolves around the level at which the postprofessional graduate performs these competencies: managing increasingly more complex situations, the breadth and depth of knowledge the postprofessional graduate brings to bear on the situation, and the higher level clinical reasoning utilized. We assumed the postprofessional graduate should be able to do all the things the entry-level student is expected to do. Therefore, we expect participants to begin a postprofessional program having already met the entry-level competencies, build upon them, and then be able to demonstrate competency in the knowledge, skills, and behaviors described within this document.

Work of the Taskforce

Taskforce members were chosen for their expertise in geriatric physical therapy and their status as a Board-certified Geriatric Clinical Specialist, involvement in postprofessional geriatric residency programs, graduates of residency programs, or involvement in the Geriatric Specialty Council. Taskforce members developed an initial list of sub-competencies; first, working in pairs and then as a committee of the whole. Review and revisions continued until all taskforce members agreed on all sub-competency statements. The resultant first draft document was shared with all AGPT members in the fall of 2016, and public comment was solicited. Those who commented provided feedback on the content and face validity of

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the document and further revisions were made. The second draft of the document was circulated to selected stakeholders based on their knowledge of postprofessional education, and their feedback was incorporated into the final review by the taskforce. Final taskforce consensus and approval of the Essential Competencies in the Care of Older Adults at the Completion of a Physical Therapist Postprofessional Program of Study document was achieved in January 2017 and then prepared for distribution to our membership. The following document represents the final work of this taskforce. The Academy of Geriatric Physical Therapy strongly encourages accredited physical therapist postprofessional geriatric educational programs to assure that their graduates demonstrate competence in each of the competencies described below.

Special Considerations

The choice of some terms used in these competencies are explained as follows:

- **Older adult:** We chose this phrase based on the wide adoption of the phrase among a variety of organizations and within the scientific literature.⁶ Public comments solicited for this document supported this choice of language. Furthermore, it is consistent with the other AGPT Essential Competency documents. However, we can find no agreed upon age that qualifies one as an 'older adult' anywhere in other AGPT documents, the DSP for geriatrics, or among the myriad of organizations that deal with this population in one way or another. The World Health Organization, who turned to the United Nations for guidance, stated: "At the moment, there is no United Nations (UN) standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population."⁷ Therefore, in general, this is the age this document references when referring to an 'older adult.'
- **Interprofessional:** We opted to use this term as opposed to interdisciplinary. The terms are often used interchangeably, despite arguments that they are different. Multiple references are available on this discussion; however, this taskforce gravitated towards the following distinction: A discipline is 'a field of study' and a profession 'a calling requiring specialized knowledge and often long and intensive preparation.'⁸ Therefore, we endorsed the term 'interprofessional.'

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4. Academy of Geriatric Physical Therapy. Essential Competencies in the Care of Older Adults at the Completion of the Entry-level Physical Therapist Professional Program of Study. 2011. <https://geriatricspt.org/essential-competencies/>. Accessed February 10, 2017.

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5. American Geriatrics Society. Multidisciplinary Competencies in the Care of Older Adults at the Completion of the Entry-level Health Professional Degree. 2010. http://www.americangeriatrics.org/about_us/partnership_for_health_in_aging/multidisciplinary_competencies/multidisciplinary_competencies778926/. Accessed February 10, 2017.
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 7. World Health Organization. Health Statistics and Information Systems. 2002. <http://www.who.int/healthinfo/survey/ageingdefnolder/en/>. Accessed February 10, 2017.
 8. Mu K, Royeen CB. Interprofessional vs. interdisciplinary services in school-based occupational therapy practice. Occup Ther Int. 2004;11(4):244-247. doi:10.1002/oti.214.
- C. **Assess and modify specific risks and barriers to older adult safety, including falls, elder/vulnerable adult abuse and neglect, ageism, and other risks in community, home, and healthcare environments.**
 1. Perform health, fitness and wellness screens (eg, screens for fall risk, incontinence, depression, weight abnormalities, elder abuse, environmental hazards) that identify older adults at risk of injury.
 2. Make referrals to appropriate providers as necessary (eg, driving safety, vulnerable adults, home modifications, etc.).

DOMAIN 1: Health Promotion and Safety

A. Advocate for and with older adults and their caregivers about interventions and behaviors that promote physical and mental health, nutrition, functional mobility, safety, social interactions, independence, and quality of life.

1. Identify, apply, and evaluate best available evidence to advocate for and with older adults and their caregivers about interventions and behaviors that promote physical and mental health, nutrition, functional mobility, safety, social interactions, independence, and quality of life across domains and care delivery settings.
2. Value the advocacy role of the physical therapist in promoting the health and safety of older adults at the individual, institutional, community and societal levels.
3. Uses evidence based strategies (eg, motivational interviewing) and behavioral interventions to promote adherence to recommendations for lifestyle modifications, health promotion and wellness.

B. Identify, apply, and inform older adults and their caregivers about evidence-based approaches to screening, health maintenance/promotion, and disease prevention.

1. Translate best available evidence about screening, health maintenance, health promotion, disease and injury prevention to patients, clients, and caregivers in a culturally appropriate manner using health literacy principles.
2. Implement disease prevention, health maintenance, health promotion, fitness, and wellness education programs that incorporate best available evidence, including the behavioral sciences, targeted to older adults and their caregivers.

D. Apply the principles and practices of safe, appropriate, and effective medication management in older adults.

1. Utilize up-to-date evidence-based medication resources clarifying common uses, side-effects, and signs and symptoms of abuse, addiction and under and overdosing of prescription and non-prescription medications commonly used by older adults.
2. Modify patient management based on common pharmacokinetic factors that should be considered when developing a plan of care and providing physical therapy interventions to older adults.
3. Describe and integrate the influence of age and polypharmacy on pharmacokinetics and drug interactions into the physical therapy plan of care.

E. Apply knowledge of the indications and contraindications for, risks of, and alternatives to the use of physical and chemical restraints with older adults.

1. Define physical and chemical restraints as they relate to physical therapist practice.
2. Identify regulatory agencies responsible for monitoring and enforcing restraint policies across healthcare settings.
3. Cite evidence that validates the impact of physical and chemical restraint use on the restrained individual, the restrained individual's caregiver(s), and society.
4. Describe and advocate for alternatives to physical and chemical restraint use that are safe and least restrictive (eg, positioning devices, enabling devices, environmental adaptation, caregiver/care-worker supervision or intervention).

DOMAIN 2: Evaluation and Assessment

A. Evaluate the purpose and components of an interprofessional, comprehensive geriatric assessment and the roles individual disciplines play in conducting and interpreting a comprehensive geriatric assessment.

1. Describe the concept of, and various formats for, interprofessional, comprehensive geriatric assessment and explain this approach compared to single discipline assessment for complex older adults.

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2. Describe the role and contributions of each member of a typical comprehensive geriatric assessment team (such as geriatrician, geriatric nurse practitioner, pharmacist, physical therapist, social worker, case manager, occupational therapist, speech language pathologist).
 3. Develop, coordinate, and engage in interprofessional collaboration based on identified opportunities, advocating for the role of the physical therapist in consultation and diagnosis of movement system impairments in the care of older adults across the continuum.
- B. Apply knowledge of the biological, physical, cognitive, psychological, and social changes commonly associated with older.**
1. Incorporate knowledge of normal biological aging across physiological systems, effects of common diseases, and the effects of inactivity when interpreting examination findings and establishing intervention plans for older individuals.
 2. Evaluate, assess, and appropriately respond to normal biological changes of the physiological systems that commonly occur with aging and as a result of diseases common in older adults.
 3. Interpret an older adult's behavior within the context of various psychological and social theories of aging; selecting appropriate action including referral when appropriate.
 4. Evaluate the differences between typical, atypical, and optimal aging with regards to all systems; develop appropriate recommendations to reflect the person's expectations, goals, needs, and contextual factors.
- C. Select, administer, and interpret psychometrically sound instruments appropriate for use with a given older adult to assess: a) body structures, b) body functions, c) activity limitations, and d) participation restrictions.**
1. Select, administer, and interpret psychometrically sound tests for cognition, anxiety, self-efficacy, and depression; and determine need for referral if necessary.
 2. Select, administer and interpret standardized and psychometrically sound tests and measures that can identify fall risks and mobility deficits; communicate and incorporate the findings into a comprehensive plan of care, and make recommendations to the healthcare team as needed.
 3. Objectively assess pain in any older person regardless of cognitive or communication abilities, including provocative and relieving factors, and the effectiveness of current interventions for pain relief.
 4. Select, administer, and interpret a basic nutritional assessment, including fluid intake, taking appropriate action as needed.
 5. Select, administer, and interpret a psychometrically sound test for health-related quality of life; and determine the need for referral.
- D. Identify and manage signs and symptoms of depression, dementia, and delirium; and consult with appropriate healthcare providers as needed.**
1. Consult with and refer to appropriate healthcare providers when indicated.
 2. Manage the impact of these conditions on the movement system and physical therapy plan of care.
- E. Develop verbal and nonverbal communication strategies to overcome potential sensory, language, and cognitive limitations in older adults.**
1. Identify and assess barriers to communication (eg, hearing and/or sight impairments, speech difficulties, aphasia, limited health literacy, cognitive disorders).
 2. Analyze how an older adult's abilities, contextual factors, activity limitations, and participation restrictions may impact communication during the rehabilitation process.
 3. Modify communication, including the use of adaptive equipment, to deliver effective patient management for older adults with depression, dementia, delirium, and/or anxiety, or for older adults who are in bereavement.
 4. Implement alternative communication methods to deliver effective patient management for older adults with limited health literacy, hearing, sight impairments, or speech difficulties.
 5. Consult other members of the interprofessional team and make referrals where appropriate.

DOMAIN 3: Care Management, Intervention, and Coordination Across the Care Spectrum (Including End-of-Life Care)

- A. Develop and implement intervention plans based on best evidence and on patient-centered and patient-directed goals.**
1. Determine a physical therapy diagnosis and prognosis that is evidence-based and grounded in the International Classification of Function (ICF) model.
 2. Develop and implement an evidence-based and person-centered physical therapy plan of care, including appropriate interventions for conditions commonly encountered in older adults, utilizing the ICF model, emphasizing the movement system, and considering principles of optimal aging across physiological systems:
 - Musculoskeletal (eg, osteoarthritis, spinal stenosis, degenerative disc disease, fractures, joint arthroplasty, amputation, post-total knee arthroplasty, post-total hip arthroplasty, post-hip fracture, disuse atrophy, chronic pain, fibromyalgia, sprains, strains).
 - Neuromuscular (eg, stroke, traumatic brain injury, encephalopathy, Parkinson's disease, Alzheimer's disease, degenerative joint disease with spinal nerve compression injuries, critical illness myopathy, peripheral neuropathies, vestibular disorders, and other sensory dysfunctions).
 - Cardiovascular and Pulmonary (eg, post-myocardial infarction, post-coronary artery bypass surgery, respiratory failure, peripheral venous disease, peripheral artery disease, cardiomyopathy, chronic obstructive pulmonary disease, pneumonia, congestive heart failure, aerobic deconditioning).

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- Integumentary (eg, cellulitis, pressure ulcers, vascular insufficiency ulcers, diabetic wounds, neuropathic wounds, burns).
 - Endocrine (eg, osteoporosis, diabetes mellitus).
 - Genitourinary (eg, urinary tract infections, incontinence), Renal (eg, renal failure syndrome [acute and chronic]), and Gastrointestinal (constipation, gastroesophageal reflux disease, malabsorptive syndromes).
 - Multi-system conditions (eg, cancer, autoimmune diseases, lymphedema).
3. Develop and implement evidence-based prevention and risk reduction programs for conditions prevalent in older adults (eg, skeletal demineralization, sarcopenia, frailty, deconditioning, flexibility restrictions, falls, cardiopulmonary disorders, impaired integumentary integrity, postural deficits).
 4. Develop and implement a plan of care for the physical therapy management of patients or clients with complex medical profiles, including multiple comorbidities and significant pharmacological considerations (eg, frequent falls, frailty, heart failure, mechanical ventilation dependency, multiple chronic health conditions, cognitive impairment, malignant neoplasm, multiple traumatic injuries, sepsis, acute infectious disease, persistent pain).
 5. Use evidence-based assessment and patient/client management tools to adapt a plan of care that addresses disabling psychosocial factors (eg, depression, learned helplessness, limited health literacy, anxiety, fear of falling, absent or unsuitable social or caregiver support systems, victim of abuse or neglect, personality disorders, and cognitive impairments).
 6. Address environmental modifications, adaptive devices/equipment and orthotics/prosthetics to optimize patient safety, function and independence.
- B. Evaluate clinical situations where standard treatment recommendations, based on best evidence, should be modified with regard to older adults' preferences, goals, life expectancy, comorbid conditions, and functional status.**
1. Create, design, and actualize intervention modifications based upon patient or client values and lifestyle, life expectancy, comorbid conditions, pharmacological profile, lab values, domicile setting, financial resources, and availability of caregivers and caregiver support.
 2. Create, design, and actualize environmental modifications to the clinical practice settings that best meet the needs of older adult (eg, equipment adaptations, privacy, lighting, climate control, accessibility, and technology to assist aging in place).
- C. Develop advanced care management plans based on older adults' preferences, goals, and their physical, psychological, social, and spiritual needs.**
1. Advocate for and initiate appropriate discussions and referrals regarding advance directives.
 2. Facilitate transition from restorative care to palliative care at the appropriate time, considering the medical and physical therapy prognosis, and supporting the psychological, social, and spiritual needs of the patient and caregiver.
3. Develop physical therapy plan of care for older adults receiving end-of-life care which integrates the patient or client goals, treatment setting, and functional and palliative needs of the patient or client and caregiver.
- D. Recognize the need for continuity of treatment and communication across the spectrum of services and during transitions between care settings, utilizing information technology where appropriate and available.**
1. Explain, summarize, and participate in a variety of methods used to communicate among healthcare professionals regarding the status and well-being of older adults (eg, team meetings, electronic documentation and review of health records, falls surveillance tools, community visit sessions, patient self-report inventories regarding health behaviors and functional status).
 2. Explain, summarize and apply relevant evidence guiding best practice regarding continuity of treatment across services and during transitions between care settings.
 3. Facilitate the continuity of treatment across services and during transitions between care settings as reflected in patient advocacy and communication among providers.
 4. Explain and summarize the benefits of community centered wellness programs; advocate for participation in health promotion, and preventative care for older adults to optimize quality of life, independence and function.

DOMAIN 4: Interprofessional and Team Care

A. When appropriate, distinguish among, refer to, and consult with any of the multiple healthcare professionals and providers who work with older adults, to facilitate positive outcomes and minimize negative outcomes.

1. Facilitate communication and collaboration with appropriate healthcare professionals or providers for referral and consultation to best meet the specific needs of an older adult.
2. Provide consultation within the physical therapy scope of practice regarding appropriate evidence-based management of movement system disorders and impairments for the older adult.
3. Develop effective methodologies for patient specific, goal oriented treatment schedules, coordinating with families, caregivers and other providers engaged in interventions to provide optimal care, including participation and learning environments. This may include medication administration, transportation or access challenges, sequential interventions, patient fatigue, treatment environments, access to community resources or support services (eg meals on wheels, condition specific support groups) and third-party payor regulations and policies.

B. Communicate and collaborate with older adults, their caregivers, healthcare professionals, and direct care workers to incorporate discipline-specific information into overall team care planning and implementation.

1. Select, prioritize, and communicate essential physical therapy diagnoses and prognosis that optimizes abilities,

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- addresses activity limitations and participation restrictions, and contributes to a team care plan.
2. Provide critical information and training to others in order to assure patient safety, facilitate care coordination, minimize risks, and promote optimal functional outcomes.
 3. Adapt communication to accommodate learning styles and cultural, generational, mental status, social, geographical, and educational perspectives and stressors affecting:
 - Older adults
 - Caregivers
 - Healthcare providers
 - Direct care workers
 - Family members and/or healthcare surrogates

DOMAIN 5: Caregiver Support

- A. **Assess caregiver knowledge and expectations of the impact of advanced age and disease on health needs, risks, and the unique manifestations and treatment of health conditions.**
 1. Effectively assess and improve caregiver knowledge and perceptions of the functional impact of advanced age and health conditions on optimal aging.
 2. Determine caregiver expectations of the health needs of his or her patient, client, or family member; as well as caregiver ability to recognize and manage manifestations of the patient's, client's, or family member's expectations and common health conditions.
 3. Communicate with caregivers in a culturally competent and age-appropriate manner that takes into consideration the health literacy level and learning style of the caregiver.
- B. **Assist caregivers to identify, access, and utilize specialized products, professional services, and support groups that can assist with care-giving responsibilities and reduce caregiver burden.**
 1. Assess caregiver and patient goals for the caregiving relationship, identify potential areas for conflict, implement strategies to resolve those conflicts within the physical therapy scope of practice, and refer to other providers as appropriate.
 2. Analyze needs, make recommendations, and assess outcomes for products, services, community resources/ referrals and support systems, to provide basic and instrumental activities of daily living assistance, considering the individual needs of the patient and caregiver, with sensitivity to resource constraints.
 3. Advocate for caregiver access and empower the caregiver to actively seek access to appropriate services and products that reduce caregiver burden and support effective care.
 4. Utilize preventative strategies to minimize the risk for caregiver burnout, and quickly recognize and respond to signs and symptoms or change in condition in order to maximize patient outcomes.
- C. **Know how to access and explain the availability and effectiveness of resources for older adults and caregivers that help them the patient meet personal goals, maximize function, maintain independence, and live in their preferred and least restrictive environment.**

1. Assess physical spaces and environments to identify, prioritize, and recommend options for the least restrictive environment that maximizes physical functional ability and independence considering the individual's willingness to change, fiscal resources to bring about the change, and expected functional status over time.
 2. Educate caregiver in accessing and using resources for optimal functioning in least restrictive manner.
- D. **Evaluate the continued appropriateness of care management, plans of care, and services based on older adults' and caregivers' changes in age, health status, and function; assist caregivers in altering plans and actions as needed.**
1. Monitor and adjust the plan of care for current and anticipated changes in the patient or client, caregiver capacity, or caregiving environment.

DOMAIN 6: Healthcare Systems and Benefits

- A. **Serve as an advocate for older adults and caregivers within various healthcare systems and settings.**
 1. Utilize multiple strategies and sources of information to assess the unmet needs of older adults and caregivers.
 2. Interact with other healthcare providers and community-based organizations for the purpose of coordinating services to facilitate efficient and effective care and optimal functioning of the patient or client.
 3. Advocate for and engage older adults and various stakeholders in order to facilitate best practice for the care of older adults.
- B. **Know how to access, and share with older adults and their caregivers, information about the healthcare benefits of programs such as Medicare, Medicaid, Veteran's Services, Social Security, and other public programs.**
 1. Educate older adults, caregivers, healthcare providers, third party payers, and the public on the intricacies and interconnectedness of the various public programs for healthcare and physical therapy services available to older adults.
- C. **Provide information to older adults and their caregivers about the continuum of long-term care services and supports - such as community resources, home care, assisted living facilities, hospitals, nursing facilities, sub-acute care facilities, and hospice care.**
 1. Educate older adults and their caregivers on the purposes, benefits, admission criteria, and financial implications of geriatric rehabilitation services across the continuum of care in order to optimize outcomes.
 2. Assess available resources and provide consultation to facilitate community dwelling older adults' ability to live independently (eg, meal delivery, home care resources, social services, electronic alert devices, community support groups, transportation services, home modifications, adaptive equipment, avocation, and recreation/sport programs).