Written Testimony of

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Good morning, Chairman Alexander and Ranking Member Murray, whom I am proud to say is my Senator, and distinguished Members of the Committee. Thank you for this opportunity to speak with you today about the value of the Geriatrics Workforce Enhancement Program (or "GWEP"), administered by the Health Resources and Services Administration (HRSA). The GWEP is the only U.S. government program dedicated to preparing primary care providers to care for older adults. My name is Elizabeth Phelan, and I am a clinically active internist and fellowship-trained geriatrician. I direct one of the only fall prevention clinics in the country, and I am also the director of the Northwest Geriatrics Workforce Enhancement Center, one of 44 GWEPs nationally. Our GWEP is a member of the National Association for Geriatric Education (NAGE), and our GWEP leaders are members of The Gerontological Society of America (GSA). I have devoted my career to improving primary care of older adults, particularly care of conditions that disproportionately afflict adults in later life, such as falls, osteoporotic fractures, and dementia.

May is Older Americans Month, --- a time to recognize and celebrate the value and contributions of older adults in our lives. Unfortunately, many older adults are suffering from conditions that, if not properly managed, will rob them of their well-being and independence. Conditions like falls, depression, and heart failure. I will give you just two examples, from a myriad of examples that I could cite, to illustrate the nationwide challenge that we face. First, there is Mr. H, a 68 year old from Montana who lives in his own home, was taking Ambien, a sleeping pill for insomnia, who got up one night and fell, breaking his pelvis. At the hospital, it was discovered that he was likely suffering from undiagnosed sleep apnea. If sleep apnea had been diagnosed and treated, Mr. H may have avoided Ambien and the injurious fall he sustained. Recent data has found that obstructive sleep apnea is diagnosed in just 8% of older adults. As another example, Mrs. W, an 80 year old female, widowed for the past 10 years, who lives in a rural part of Florida and also in her own home, who is absolutely paralyzed by anxiety and panic attacks. Because of the anxiety, she no longer drives and has become very socially isolated. Her doctor is treating her with Xanax. Xanax and other medications in this same class are very risky for people in later life, *and* Xanax is ineffective for anxiety and panic. In essence, it is just putting a band-aid on the condition.

Why does medical mismanagement of older adults like this occur? Is it that there are bad apples in medical practice? No. Most health care providers want to do the right thing for their patients. But when it comes to care of older adults, most don't know what the right thing is. That is because geriatrics, or the clinical care of the elderly, has not been a part of the training of most health professionals in practice today. And even those in current training for health professions careers usually still get to the end of their training and never receive any formal exposure to geriatrics. With GWEP funding, we have the opportunity to change that.

GWEPs focus on enhancing the ability of America's primary care workforce to provide high-quality care for older adults. Our Northwest Geriatrics Workforce Enhancement Center is working to achieve the vision that wherever an older adult goes for primary care, he/she will encounter a provider who is

prepared to meet his/her needs and to provide the right care at the right time – that is, care that is tailored to the older adult's health and functional status, and his/her personal goals and preferences. Our Center has chosen to focus training on the next generation of primary care providers, and we are taking a comprehensive, inclusive view of primary care. A key target for our educational activities are the resident physicians in the Family Medicine Residency Network, a network of 25 independent residency training programs in a five-state region known as "WWAMI" (Washington, Wyoming, Alaska, Montana, and Idaho). We are also training nurse practitioner and physician assistant students and those on the front lines of hands-on, daily care, including family caregivers and home care workers.

How exactly is our Center preparing the next generation of primary care providers to provide high-quality, evidence-based care for older adults? We are doing this in a number of ways. For example, we have adopted the ECHO® model to teach general principles of geriatrics and reach family medicine resident physicians and nurse practitioner and physician assistant trainees across the Pacific Northwest. We have partnered with two Area Agencies on Aging and are using about a third of our GWEP dollars to fund a position within those agencies that we call a Primary Care Liaison, whose role is to actively outreach to primary care practices with education about how Area Agencies on Aging can support the work of primary care by bringing community resources to bear. We are trying to break down silos of care between clinic and community, because care that is tuned into the resources that the community can bring to bear can optimize the health of an older adult and keep him/her living in the community – AND avoid the unnecessary costs of hospitalizations and long-term care that so often otherwise results. And we are finding that <u>even minimal exposure</u> to geriatrics principles of care makes a difference in trainee knowledge and confidence to bring AAA resources to bear on the care of their older patients. For example, with our AAA Practicum, family medicine residents who spent just one day with an AAA staff member, after exposure to a standard curriculum developed by our AAA partners about the role of AAAs, significantly increased their likelihood to access family caregiver resources, elder abuse resources, and mental health resources on behalf of their patients.

We know we have a shortage of primary care workforce, and there are a number of ways that we can address this, but ALL need training in geriatrics. Because most older adults will continue to receive primary care from frontline providers from the fields of family medicine, general internal medicine, and nurse practitioners, – not geriatricians, — we must support the training of providers in those disciplines to make good care a reality. We have a long way to go to realize this imperative. Doing the right thing does have a large impact on how well an older adult lives and how long he/she stays living in the community. For this reason, I urge the entire committee to continue to support the Geriatrics Workforce Enhancement Program. Thank you again for this opportunity to testify, and I look forward to answering your questions.