Statement of
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Mr. Chairman and Members of the Subcommittee,

My name is Michael C. Martin and I am the Executive Director of the Commission for Certification in Geriatric Pharmacy (CCGP). I would first like to commend the Members of this committee for their support and work on legislation to assist seniors gain access to improved care under Medicare, and to receive coverage for prescription drugs, and to improve the quality of care in nursing facilities. In addition, I would like to commend the Members' current interest in enacting federal standards in assisted living facilities to improve quality of care.

CCGP was invited by the Alliance for Aging Research to join their efforts to unite the health professions in addressing the critical lack of geriatric-trained health care professionals. Effectively caring for the elderly requires a cooperative effort among the entire health care team. I am here today to discuss the role of pharmacists in the interdisciplinary health care team and specifically how Certified Geriatric Pharmacists (CGPs) can improve the medication therapy management of seniors. I also will address areas in which Congressional action can help to increase seniors' access to the expertise of pharmacists.

CCGP was founded in 1997 by the American Society of Consultant Pharmacists (ASCP) to oversee the certification program in geriatric pharmacy practice. ASCP is the international professional society representing senior care pharmacists to provide medication therapy management and distribution services to the senior population in nursing homes, assisted living facilities, adult day care centers, retirement communities, and in the home. CCGP was created to recognize and certify those pharmacists who have the special knowledge, skills, and abilities to provide comprehensive pharmaceutical care to the elderly. CCGP is a nonprofit corporation, autonomous from ASCP and with its own governing Board of Commissioners. CCGP is responsible for establishing certification standards, developing and administering the Certification Examination in Geriatric Pharmacy, establishing eligibility criteria and program policies, and issuing credentials. Candidates who successfully meet all program requirements receive the designation "Certified Geriatric Pharmacist" or CGP.

To earn the CGP credential, pharmacists must demonstrate their expertise through a rigorous, three-hour, psychometrically sound certification examination. The 150-item multiple-choice CCGP exam is designed to assess candidates' knowledge in three areas of practice: patient-specific activities (34%), disease-specific activities (56%), and quality improvement/utilization management activities (10%). The exam was developed by a 12-member committee of geriatric pharmacy practitioners and educators under the guidance of CCGP testing contractor Applied Measurement Professionals, a nationally prominent testing company based in Lenexa, Kansas.

The CGP designation can help ensure consumers that the pharmacist has special knowledge regarding the needs of the senior population. CGPs can be effective in any setting to manage seniors' medication regimens, including hospitals, the community, and long-term care.

Currently, the CGP designation is the only designation that recognizes the clinical expertise of

these senior care pharmacists. This designation has been recognized in the pharmacy practice acts of Arizona, North Carolina, and Ohio. The CGP credential also has been recognized by the Department of Veterans Affairs and is recognized in Australia and Canada. Yet, only 720 out of nearly 200,000 pharmacists in the United States have received the CGP designation. The reasons for this include the following:

• Lack of federal recognition of pharmacists under the "Social Security Act" makes pharmacists unable to bill Medicare and Medicaid for the clinical services that they provide to manage patient medication therapy. To remedy this situation, Senator Tim Johnson introduced S. 974, "The Medicare Pharmacists Services Act," that would recognize pharmacists under the "Social Security Act" and bill Medicare for the services they provide.

• Most pharmacists who currently specialize in senior care have acquired these skills on the job because until recently the clinical literature lacked data regarding the effects of medications on seniors, particularly the "old, old", age 85 and older, the fastest growing segment of the population. Because of the effects of aging on the body, seniors require very specific dosing adjustments to ensure that toxicity leading to medication-related problems do not occur. However, until recently and even now, clinical literature does not provide the necessary information to appropriately provide care. As a result, many pharmacists are not confident with their ability to manage the medication therapy of seniors much less become certified in geriatric care. This committee should sponsor and support legislation to require additional pharmaceutical research regarding the effect of medications on the elderly.

• Lack of formal training in geriatric pharmacy. Currently, schools of pharmacy often lack the availability of curriculum in geriatric care. Students should be trained in schools of pharmacy regarding the special needs of seniors. The lack of expertise among current pharmacists leads to a vicious cycle of a lack of experts to teach students to become geriatric pharmacists. Just like the need exists for schools of pharmacy to develop curriculum to teach students, incentives need to be provided for students to complete experiential rotations at hospitals, nursing homes and other long-term care facilities, and in the community to provide for the special needs of seniors.

• As this committee is patently aware, a shortage of pharmacists currently exists in the United States. This means that pharmacists often work 6-7 days a week leaving little time for preparation for a rigorous exam to earn a credential in geriatrics. This could be relieved through legislation proposed by Representative Jim McGovern in the House. This bill would provide federal funding to schools of pharmacy to increase the number of pharmacists to relieve the current shortage.

There have been promising signs that interest in geriatrics, and the awareness of the impending crisis in health care for older Americans, is increasing. There are countless advocacy groups representing the aging, nearly all educational institutions address geriatrics, and frequent reports in the media on health issues among older Americans reflect the growing importance of this issue. But it's clear that the rate at which medical schools, pharmacy schools, nursing, and other health care disciplines are producing individuals who have the motivation and expertise to manage this complex population continues to lag behind its staggering growth.

There are a number of reason why geriatrics has not been a popular specialty for health care providers. These include: the complexity of care for older patients; an unfortunate lack of

interest in individuals approaching the end of their lives; and, most significantly, a lack of payment mechanisms that address the unique medical approach required to effectively manage older patients.

This lack of emphasis on the special medication needs of seniors must end. Currently, medication-related problems cost the United States health care system more than $200 billion per year (approximately 60 percent can be attributed to the geriatric population) and are the fifth leading cause of death in the United States. These medication related problems including adverse drug reactions, improper dosing (over or under prescribing), multiple medications for the same indication, and drug induced hospitalizations are often preventable. In fact, a 1997 study published in the *Archives of Internal Medicine* found that in nursing facilities, interventions by consultant pharmacists reduced the number of patients who experienced a medication related problem by almost 50 percent and saved $3.6 billion per year in these settings.

The need for pharmacists' intervention, particularly CGPs, will become more acute as medications become a more integral part of medical therapy. While medications may replace other more invasive medical interventions such as surgery, they are sophisticated technology that require careful monitoring by highly trained professionals. This need will increase when Medicare finally provides seniors with a drug benefit. Already, seniors age 65 and over consume nearly one-third of the one billion prescriptions dispensed each year. The percentage of prescription products consumed by seniors will continue to grow as millions of baby boomers age and require medications for chronic conditions. In addition, the number of prescriptions dispensed continually increases each year and this number will also increase.

To assist pharmacy and the geriatric population gain access to the types of services necessary to ensure the highest quality of care; I urge the committee and your colleagues in Congress to take the following steps:

- Pass a Medicare prescription drug benefit that includes pharmacy for pharmacist medication therapy management services. This legislation should recognize the CGP designation for pharmacists who participate in medication therapy management.

- Pass legislation to recognize pharmacists under the "Social Security Act" to allow pharmacists to be paid directly for the clinical services they provide.

- Pass legislation to provide funding for additional pharmacists to relieve the shortage and to provide incentives to bolster geriatric curriculum in schools of pharmacy.

- Provide funding for pharmacist residency programs in geriatric care.

- Preserve the federal nursing facility standards and the requirement that consultant pharmacists provide drug regimen review to reduce medication related problems.

Much of the tragic waste of health care resources, and even more tragic consequences to our nation's seniors is preventable. In Medicare and Medicaid certified nursing facilities, for example, federal standards require that a consultant pharmacist review every resident's prescribed drug regimen at least once a month, and report concerns and recommendations to physicians. These professional services provided by the pharmacist save millions every year

by preventing or resolving medication-related problems. Every Medicare and Medicaid-eligible senior should be afforded, as a basic protection, the kind of pharmacist-conducted medication supervision that protects today's nursing facility residents.

When nursing facility reforms, including requirements for monthly drug regimen reviews conducted by a consultant pharmacy, were enacted in 1974, the typical nursing home resident was indistinguishable from today's assisted living resident. The health status and medication use patterns of seniors who reside in assisted living facilities and in the community are nearly identical to those of nursing facility residents.

Thirty years ago, many individuals were placed in nursing homes because of incontinence or other disability that today can be managed by drug therapy or improved support systems. But the kind of abuses, poor supervision, and inadequate care that led to federal nursing home reforms are already being seen in the growing assisted living environment.

There are no federal standards protecting residents of assisted living facilities, nor for Medicare- or Medicaid-eligible seniors in a variety of other settings. And, of course, while the Medicare program does not pay for outpatient prescription drugs for community dwelling seniors, it pays billions for the health consequences of medication-related problems.

Pharmacists save lives. They can save more, as well as millions of health care dollars, if mechanisms are in place that pay qualified pharmacists for their professional medication consulting services, either as part of compensation for dispensing pharmaceuticals, or as a separate clinical service.

Certified Geriatric Pharmacists, the experts in monitoring pharmacotherapy in seniors, are uniquely qualified to identify individuals who are at high risk for medication-related problems, or to identify and resolve health problems that are not being recognized as drug-related. Pharmacists act as patient advocates on behalf of the seniors they serve, working with physicians, nurses, caregivers, family members, and other health professionals to protect seniors from drug related problems and improve their quality of life.

Certified Geriatric Pharmacists are particularly aware that seniors, such as those living in nursing facilities, are often forgotten. Many nursing facility residents have no family, or receive visitors only rarely. They may be difficult to manage and hard to communicate with, but geriatricians, pharmacists, nurses, and other's dedicated to geriatric medicine serve as their advocates, and recognize their value.

If we continue to neglect the health care needs of seniors, the health care system will face collapse under the incredible cost of tens of millions of seniors living into their 70s, their 80s, their 90s, and beyond. Care for the elderly requires looking at the whole patient, not just a disease or an organ system, to anticipate the enormous health risks facing nearly every senior. It is a focus not on one ailment, or even on the management of symptoms, but of preserving the patient's ability to live as independently as possible, to allow them to continue, as long as possible, to perform their activities of daily living and to preserve their functionality.

Yes, seniors want to be free of pain, and they want to manage their symptoms and chronic illness. But what seniors want most of all is to preserve their independence, to avoid being a burden to others, to be treated with respect and consideration. In seniors, drug related problems cannot be viewed in isolation, nor even can a review of all the drugs a geriatric

patient consumes yield a complete picture of the risk for drug-related problems.

For example, the consensus of opinion among researchers and clinicians is that an elderly individual who takes nine or more medications should be considered at risk for medication related problems. That's a conclusion you could draw without any additional information about the patient. But a senior taking only four different prescribed medications who also has a history of falls or incontinence is also considered to be at risk for medication problems, according to a consensus drawn from evidence-based research.

Why? Because a potentially catastrophic event for a senior, such as a fall, is actually a medication-related problem. Health care providers who are not specialists in the care of the elderly may not recognize it as such, but medications that cause dizziness, or that make a senior get up to go to the bathroom in the middle of the night and suffer a fall and a broken hip, constitute a medication-related problem.

As a result, we pay for emergency room visits, hip replacement surgery, physical therapy, repeat visits to the hospital, treatment for stroke, and nursing home care. That's how a relatively healthy senior, with one medication-related event, can go from independence to tragedy. We don't pay for the relatively simple measures that could have prevented all that suffering, and all that expense.

Identifying these kinds of risk factors requires health care specialists that look at the whole patient, and who understands the extraordinary complexity of drug therapy in a patient with altered metabolism, physical disabilities, multiple chronic illness, limited caregiver support, neurological and psychological problems, and myriad other factors.

Effective care of seniors requires an interdisciplinary approach, including pharmacists, physicians, nurses, physical therapists, nutritionists, care managers, and others. The efforts of these professionals to prevent life-threatening, costly health care problems among the elderly must be appropriately compensated. This is cost-effective care that simply doesn't fit with our current thinking about payment for medical services.

We must reform the way our nation approaches medical care for seniors. Effective health care for seniors requires a coordinated assessment and case management provided by an interdisciplinary team focused on the patient's overall well-being. Public and private health care systems simply do not pay for that kind of care. Instead, they pay for expensive tests and treatments, but not for the kind of care needed to identify the at-risk elderly and protect them from potentially life threatening medical problems.

I would like to commend the members of the Senate Special Committee on Aging for the leadership role it has played in raising our nation's awareness of the health care needs of the elderly, and in taking insightful initiatives to address their unmet needs. Seniors are unique patients who require and deserve the care of unique pharmacists.

Again, thank you very much for this opportunity to appear before you to address this important national issue and we look forward to working with you on this issue in the future.