AGS UPDATED 2015 BEERS CRITERIA FOR POTENTIALLY INAPPROPRIATE MEDICATION USE IN OLDER ADULTS

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THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals. Leading Change. Improving care for older adults.
Disclosures

Todd Semla, MS, PharmD

- Spouse is an employee of Abbvie and owns stock in Abbvie and Abbott Labs
- Dr. Semla received honoraria from the American Geriatrics Society, LexiComp, and CVS Omnicare in 2015
- The views and opinions expressed by Dr. Semla are his own and do not necessarily reflect those of the U.S. Department of Veterans Affairs or the U.S. Government.

Peter Hollmann, MD

- Member NCQA Geriatric Measures Advisory Panel (Travel paid to GMAP meetings)
Objectives

- Describe changes to AGS Beers Criteria and provide updates
- Examine combinations of medications known to cause harmful ‘drug-drug’ interactions
- Discuss effective and safer alternative treatments for HEDIS high risk medications.
- Understand the AGS position on Use of Criteria and (Quality Measures, Formulary)
AGS Beers Criteria is explicit evidence based clinical guidance that can improve care. It was updated in 2015.

The Criteria include multiple sections (including PIM, Drug Drug, Drug Disease)

Quality Measures Can Stimulate Improved Care.

There are drug and non drug alternatives to many PIMs
“A ballet-dancing opera critic who hiked the Alps and took up rowing after diabetes cost him his legs”

- MD, Univ of Vermont
- First med student to do a geriatrics elective at Harvard’s new Division on Aging
- Geriatric Fellowship, Harvard
- Faculty, UCLA/RAND
- Co-editor, Merck Manual of Geriatrics
- Editor in Chief, Merck Manuals
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or
Open poll in your web browser
How Much Do You Like the Beers Criteria?

- Completely and totally fabulous
- Good, but implementation in practice causes problems
- Don’t like other people telling me how to practice
- Don’t agree with criteria
Why is inappropriate medication use important in older adults?

- Increases mortality, morbidity & risk of adverse drug events (Lau et al., *Arch Intern Med*, 2005)
- Is increasing in use in the oldest and most vulnerable adults (Olfson et al., 2014, Davidson et. al., 2015)
TOO MANY DRUGS - IS RESTRAINT NEEDED?

PIMS--Way to eliminate bad drugs

- The Biggest independent predictor of ADEs is the number of drugs the older adult is taking

Less is More

- “To do nothing is sometimes a good remedy” (Hippocrates (circa 460-377 BC)
What is the purpose of the Beers Criteria?

- To identify drugs to avoid in older adults: 1) Independent of diagnosis, 2) Considering diagnosis

- To reduce adverse drug events and drug related problems and improve medication selection and medication use in older adults

- Designed for use in any clinical setting, also used as an educational, quality and research tool
Beers Criteria: History and Utilization

- Original 1991 – Nursing home pts

- Updates
  - 1997 All elderly; adopted by CMS in 1999 for nursing home regulation
  - 2003 Era of generalization to Med D, NCQA/HEDIS
  - 2012 Further adoption into quality measures
  - 2015 Introduction Drug-Drug Interactions, Renal Dosage Tables, How to Use Paper
Specific Aims 2015 AGS Beers Criteria

Specific aim: Update 2012 Beers Criteria using a comprehensive, systematic review and grading of evidence

Strategy:
- Incorporate new evidence
- Grade the new evidence
- Use an interdisciplinary panel with consensus
- Incorporate exceptions
Intent of the AGS 2015 Beers Criteria

Goals:

- Improve care by ↓ exposure to PIMS
- Educational tool
- Quality measure
- Research tool

Prescribing measure vs. Quality measure
Method

Framework

- Expert panel
  - 13 members

- IOM 2011 report on guideline development
  - Includes a period for public comment

- Extensive Literature Search
Panel Members

- **Co-chairs**
  - Donna Fick, PhD
  - Todd Semla, MS, PharmD

- **Panelists (voting)**
  - Judith Beizer, PharmD
  - Nicole Brandt, PharmD
  - Catherine DuBeau, MD
  - Jerome Epplin, MD, AGSF
  - Nina Flanagan, CRNP, CS-BC
  - Joseph Hanlon, PharmD, MS
  - Peter Hollmann, MD
  - Rosemary Laird, MD
  - Sunny Linnebur, PharmD
  - Stinderpal Sandhu, MD
  - Michael Steinman, MD

- **Nonvoting Panelists**
  - Robert Dombrowski, PharmD (CMS)
  - Woody Eisenberg (PQA)
  - Erin Giovannetti (NCQA)

- **AGS Staff**
  - Elvy Ickowicz, MPH
  - Mary Jordan Samuel

- **Others**
  - Sue Radcliff (research)
  - Susan Aiello, DVM (editing)
Assembling the Evidence

SEARCH TERMS: ADE, inappropriate drug use, med errors, polypharmacy x age/human/English

Initial Search (8/1/2001-7/1-2014)  
\[n=25,549 \text{ citations}\]

Records reviewed by co-chairs  
\[n=3,387\]

Records Screened by Full Panel  
\[(n=1,188 \text{ citations})\]

Studies Used to create Evidence Tables  
\[(n=335)\]

Records excluded due to duplication or did not meet the inclusion criteria  
\[(n=5,531)\]
METHODOLOGY & PROCESS

- Use of Beers SWAT team –
- In-person meeting: review of 2012 Criteria, SWAT Team report and lit search
- 4 groups reviewed lit, selected citations
- Evidence tables prepared, rated quality of evidence and strength of recommendation
- Final group consensus—multiple meetings
### Designations of Quality and Strength of Recommendation: ACP Guideline Grading System, GRADE

#### QUALITY OF EVIDENCE - USING GRADE
- High Evidence
- Moderate Evidence
- Low Evidence

#### STRENGTH OF RECOMMENDATION
- Strong: Benefits > Harms or Harms > Benefits
- Weak: Benefits finely balanced with harms
- Insufficient: Evidence inadequate to determine harms
Use of Caveats

- Many medications are considered potentially inappropriate only in certain circumstances, or in most circumstances but with some key exceptions. These distinctions are highlighted in the rationale and recommendations statements for each criterion, and are vital for proper interpretation and use of the criteria.
How to Use the American Geriatrics Society 2015 Beers Criteria—A Guide for Patients, Clinicians, Health Systems, and Payors

Michael A. Steinman, MD, Judith L. Beizer, PharmD, CGP, Catherine E. DuBeau, MD, Rosemary D. Laird, MD, Nancy E. Lundebjerg, MPA, and Paul Mulhausen, MD, MHS
Key Principles

- Medications in the AGS 2015 Beers Criteria are potentially inappropriate, not definitely inappropriate
- Read the rationale and recommendations, caveats are important
- Understand why medications are listed and adjust your approach to these medications appropriately
- Optimal application involves identifying PIMs and offering safer Rx/nonRx alternatives as appropriate
Key Principles

- The criteria are a starting point for a comprehensive process of improving medication appropriateness and safety
- Access to Beers list Rx should not be excessively restricted by PA or coverage
- The criteria are not equally applicable to all countries
Reality

- The Medicare Advantage 5 Star Quality Rating/Payment is High Stakes
- Formularies can improve care
- Quality Measures – just like clinical guidelines – are not absolute directives
NCQA and PQA (DAE or HRM)

- Based on AGS 2015 (when new revisions are implemented)
- Positive Interactions between Beers Panel and NCQA (participation by NCQA and PQA on Panel)
- Quality Measures require no caveats (unless can be claims based) and are only if Strong Recommendation
- Unintended Consequences are considered
NCQA Updates (DAE)

- Based on AGS 2015 (most changes in list are minor)
- One rate only (no 2 drug rate)
- Require TWO fills (matches PQA)
- Any use of “Z” drugs not followed – still 90 days
  - Concern re use of benzos that are not in measure due to caveats
  - Considered if caveat was rare, could add PIM to DAE
Summary of Changes to 2015 AGS Beers Criteria

New Tables
- Table 5 – drug-drug interaction
- Table 6 – renal dosing

New Drugs – Table 2
- PPI’s > 8 weeks without justification
- Desmopressin for treatment of nocturia or nocturnal polyuria

New Drugs – Table 3
- Eszopiclone and zaleplon added to list of drugs to avoid in dementia or cognitive impairment
- Opioids added to list of drugs to avoid in patients with history of falls
<table>
<thead>
<tr>
<th>Object Drug/Class</th>
<th>Interacting Drug/Class</th>
<th>Rationale</th>
<th>Recommendation</th>
<th>Quality of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha-1 blockers, peripheral</td>
<td>Loop diuretics</td>
<td>↑ risk of urinary incontinence in older women</td>
<td>Avoid in older women, unless conditions warrant both drugs</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>ACEIs</td>
<td>Amiloride or triamterene</td>
<td>↑ risk of hyperkalemia</td>
<td>Avoid routine use; reserve for patients with demonstrated hypokalemia while on an ACEI</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>Anticholinergic</td>
<td>↑ risk of cognitive decline</td>
<td>Avoid, minimize the number of anticholinergic drugs (see Table 8).</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Antidepressant</td>
<td>*Two or more other CNS drugs</td>
<td>↑ risk of falls</td>
<td>Avoid 3 or more CNS drugs, minimize the number of CNS drugs.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
</tbody>
</table>
Table 5. Potentially Clinically Important Non-infective Drug-Drug Interactions That Should Be Avoided in Older Adults

<table>
<thead>
<tr>
<th>Object Drug/Class</th>
<th>Interacting Drug/Class</th>
<th>Rationale</th>
<th>Recommendation</th>
<th>Quality of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotic</td>
<td>*Two or more other CNS drugs</td>
<td>↑ risk of falls</td>
<td>Avoid 3 or more CNS drugs, minimize the number of CNS drugs.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Benzodiazepines and benzodiazepine-receptor agonists</td>
<td>*Two or more other CNS drugs</td>
<td>↑ risk of falls/fractures</td>
<td>Avoid 3 or more CNS drugs, minimize the number of CNS drugs.</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>NSAIDs</td>
<td>↑ risk of peptic ulcer disease/GI bleed</td>
<td>Avoid; if not possible, provide GI protection.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Lithium</td>
<td>ACEIs</td>
<td>↑ toxicity</td>
<td>Avoid, monitor lithium concentrations.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Lithium</td>
<td>Loop diuretic</td>
<td>↑ toxicity</td>
<td>Avoid, monitor lithium concentrations.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
</tbody>
</table>
Medication Related Adverse Events

- Most common type of medication-related adverse events in older adults is Type A (‘augmented’) adverse drug reactions (ADRs) versus Type B (‘bizarre’).
  - Type A reactions are an exaggeration of the expected pharmacologic effect of a drug.
    - more predictable,
    - dose dependent and
    - potentially preventable.

Table 6. Non-infective Medications That Should Be Avoided or Have Their Dosage Reduced with Varying Levels of Kidney Function in Older Adults

<table>
<thead>
<tr>
<th>Medication Class/Medication</th>
<th>Creatinine Clearance (mL/min) When Action Required</th>
<th>Rationale</th>
<th>Recommendation</th>
<th>Quality of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular/Hemostasis</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amiloride</td>
<td>&lt;30</td>
<td>↑ potassium and ↓ sodium</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Apixaban</td>
<td>&lt;15</td>
<td>↑ bleeding</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Dabigatran</td>
<td>&lt;30</td>
<td>↑ bleeding</td>
<td>Avoid</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>Edoxaban</td>
<td>30–50</td>
<td>↑ bleeding</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
<td>&lt;30</td>
<td>↑ bleeding</td>
<td>Avoid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enoxaparin</td>
<td>&lt;30</td>
<td>↑ bleeding</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Fondaparinux</td>
<td>&lt;30</td>
<td>↑ bleeding</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Rivaroxaban</td>
<td>30–50</td>
<td>↑ bleeding</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td></td>
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<td>↑ bleeding</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spironolactone</td>
<td>&lt;30</td>
<td>Hyperkalemia</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Triamterene</td>
<td>&lt;30</td>
<td>Increased risk of kidney injury; ↑ potassium and ↓ sodium</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td><strong>Central Nervous System/ Analgesics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>&lt;30</td>
<td>↑ GI adverse effects (nausea, diarrhea)</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Weak</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>&lt;60</td>
<td>CNS adverse effects</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>≤80</td>
<td>CNS adverse effects</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>≤60</td>
<td>CNS adverse effects</td>
<td>Reduce dose</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Tramadol</td>
<td>&lt;30</td>
<td>CNS adverse effects</td>
<td>Immediate release: reduce dose Extended release: avoid</td>
<td>Weak</td>
<td>Weak</td>
</tr>
</tbody>
</table>
Alternatives to High Risk Medications in the Elderly

Table 1. Alternatives for Medications Included in the High-Risk Medications in the Elderly Measure

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>High-Risk Medications</th>
<th>Alternatives</th>
</tr>
</thead>
</table>

Table 2. Alternatives to Medications Included in the Potentially Harmful Drug-Disease Interactions in the Elderly*

<table>
<thead>
<tr>
<th>Diseases and Potentially Harmful Drugs</th>
<th>Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>Drugs</td>
</tr>
</tbody>
</table>

*References (Appendix 1)
# Alternatives to Common Drugs

<table>
<thead>
<tr>
<th>PIM</th>
<th>ALTERNATIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihistamine</td>
<td>Intranasal saline or steroid&lt;br&gt;Second generation antihistamine</td>
</tr>
<tr>
<td>Nonbenzo Hypnotics (Z drugs)</td>
<td>See resources for non Rx alternative&lt;br&gt;Appendix 3</td>
</tr>
<tr>
<td>Glyburide</td>
<td>Glipizide or gliclazide&lt;br&gt;Metformin</td>
</tr>
<tr>
<td>Estrogens (oral or patch)</td>
<td>Vaginal estrogen (local symptoms)&lt;br&gt;SSRI, SNRI, gabapentin (vasomotor)</td>
</tr>
<tr>
<td>Pain (Opioids, NSAIDS)</td>
<td>Tramadol; NSAIDs with PPI if no CHF and eGFR &gt; 30 ml</td>
</tr>
</tbody>
</table>
### Alternatives to Common Drug with Disease Issues

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>ALTERNATIVE To PIM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia – Neuropathic Pain</td>
<td>SNRI, capsaicin, gabapentin, lido patch</td>
</tr>
<tr>
<td>Dementia- Depression</td>
<td>SSRI, SNRI, bupropion</td>
</tr>
<tr>
<td>Dementia - Anxiety</td>
<td>Buspirone, SSTI, SNRI</td>
</tr>
<tr>
<td>Falls – depression</td>
<td>SNRI, bupropion</td>
</tr>
<tr>
<td>Falls- anxiety</td>
<td>Buspirone, SNRI</td>
</tr>
<tr>
<td>CKD (&lt;30 ml/min) - Pain</td>
<td>Acetaminophen, SNRI, capsaicin, lido patch</td>
</tr>
</tbody>
</table>
The Case of Mr. A.H.

An 81 y.o. retired insurance agent and avid golfer.

Hx: PUD 40 years ago, osteoarthritis (knees), lower back and shoulder pain (surgery for both), and COPD. Goal “to play golf until I keel over on the course”

Medications:
- Naproxen 220 mg - 1-2 twice a day x 1 year
- Budesonide-Formoterol - 2 puffs twice a day
- Omeprazole 20 mg – 1 daily

BP = 132/78 mmHg; eCrCl = 49 mL/min
Your poll will show here

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What would you do based on the 2015 AGS Beers Criteria?

1. Replace the naproxen with an opioid and stop the omeprazole
2. Start an ACE inhibitor for his hypertension
3. **Continue his present regimen**
4. Change his inhaler to tiotropium for a once a day regimen.
Recommendation

Avoid scheduled use for > 8 weeks unless for high-risk patients (e.g., oral corticosteroids, chronic NSAID use, esophageal disorders, or demonstrated need)

Rationale

Risk of *Clostridium difficile* infection and bone loss and fractures

Quality of Evidence – High

Strength of Recommendation - Strong
An 78 y.o. who’s lived alone since her husband died 3 years ago. Her chief complaint is poor sleep – wants a sleeping pill. She used to take OTC diphenhydramine and her old doctor tried trazodone, which did nothing. You prescribe zolpidem but the pharmacy says you need a prior auth. Other problems:

- HTN x 20 years; ACE inhibitor and CCB; BP 144/78
- Diabetes x 6 years; metformin, some sensory neuropathy
- Osteoarthritis; APAP as needed
Your poll will show here

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Which of the following is consistent with the 2015 AGS Beers Criteria?

1. Recommend diphenhydramine 25 mg at bedtime. It is an OTC - the PBM won’t know.
2. Get the PA for zolpidem – use clinical judgement and the PBM alternatives are really expensive and/or do not work. Or would they prefer Temazepam?
3. **Offer medication alternatives including sleep hygiene, CBT, relaxation techniques.**
4. Advise she pay cash for zolpidem. Not costly and your quality scores stay good.
Z-drugs — eszopiclone, zaleplon, zolpidem
(nonbenzodiazepine, benzodiazepine receptor agonists)

- **Recommendation**
  - Avoid – removal of 90-day duration allowance

- **Rationale**
  - Adverse effects similar to benzodiazepines (delirium, falls, fractures). Increased ED visits, motor vehicle accidents.
  - Minimal improvement in sleep latency and duration

- **Quality of Evidence** – Moderate

- **Strength of Recommendation** - Strong
AF is 79 yo woman with a hx of osteoporosis, ↑ lipids, MCI and herpes zoster with post-herpetic neuralgia. A frequent faller having fallen twice in the past month. She’s felt “low” the past 4 months admitting to low energy and little interest in her usual pleasures. Her PHQ-9 = 11.

Meds: Alendronate 35 mg per week x 2 years
Vit. D (cholecalciferol) 1000 U once a day
Donepezil 10 mg daily
Atorvastatin 20 mg daily
Gabapentin 400 mg twice a day
Your poll will show here

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Open poll in your web browser
Which of the is NOT an appropriate treatment choice per the 2015 AGS Beers Criteria?

1. Psychotherapy
2. An SSRI
3. Bupropion
4. Mirtazapine
TCAs & SSRIs – History of Falls

**Recommendation:**
- Avoid unless safer alternatives are not available

**Rationale:**
- Increased risk of falls and fractures

**Quality of Evidence:** High

**Strength of Evidence:** Strong
AF (as in Atrial Fib)

AF is 75 yo male. He has AF that is rate controlled with digoxin 0.25 mg daily. Dig levels are normal and he sees a cardiologist. He was on diltiazem once, but had problems with constipation. He also has HTN and mild DM. When you read the Beers list update, you decided to switch from Dabigatran to Apixaban. He just retired and is about to go on a Medicare Part D plan.
Your poll will show here

1. Install the app from pollev.com/app
2. Make sure you are in Slide Show mode

Still not working? Get help at pollev.com/app/help
or
Open poll in your web browser
What would a loyal Beers Criteria user do?

1. Switch back to Dabigatran
2. Start Amiodorone
3. **Decrease the dose of digoxin, adding other agents as needed for rate control.**
4. Maintain the current regimen, but check levels and creatinine every 6 months.
Recommendation
- Avoid as first line therapy in atrial fibrillation
- Avoid as first line therapy in CHF
- If used, avoid doses >0.125 mg/dl

Rationale
- AF: more effective alternatives, may be associated with increased mortality
- CHF: Effects are on hospitalization and may be associated with increased mortality
- Decreased Cr Cl increases risk toxicity, Stage 4/5 may need even lower
Digoxin

- **Quality of Evidence** –
  - AF – Moderate
  - CHF - Low
  - Dose - moderate

- **Strength of Recommendation** – Strong (all 3)
  - Amiodarone: only if rhythm control preferred and decreased LV (Table 2 PIM)
  - Dabigatran: Increased Risk GI bleed vs others, safety/efficacy unclear if CrCl< 30 ml/min (Table 4 Caution)
AGS Beers Criteria Resources

Criteria
- AGS Updated Beers Criteria
- How-to-Use Article
- Alternative Medications List

Coming Soon!
- Updated Beers Criteria Pocket Card
- Updated Beers Criteria App

Public Education Resources for Patients & Caregivers
- AGS Beers Criteria Summary
- 10 Medications Older Adults Should Avoid
- Avoiding Overmedication and Harmful Drug Reactions
- What to Do and What to Ask Your Healthcare Provider if a Medication You Take is Listed in the Beers Criteria
- My Medication Diary - Printable Download
- Eldercare at Home: Using Medicines Safely - Illustrated PowerPoint Presentation

Available at: GeriatricsCareOnline.org
Conclusions

- Beers Criteria only are useful if implemented thoughtfully in practice

- Helpful, not dogmatic

- Keep in mind key principles to help you best use Beers Criteria in practice

- Use resources (and direct your patients to them too)
Thank you for your time!

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