2012 Beers Criteria

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For longer than 20 years, the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults has been the most consulted source of information about the safety of prescribing medications for older adults. The late Mark Beers, MD, a geriatrician, first published the criteria in 1991 with the help of a team of experts. In its initial incarnation, the Beers Criteria focused on nursing home residents, identifying medications that posed risks that outweighed potential benefits in these older adults. In 1997 and 2003, Dr. Beers and colleagues updated and expanded the scope of the criteria to include medications that were potentially inappropriate for all adults aged 65 and older, regardless of where they lived or received care. Although the Beers Criteria is best known as an invaluable reference for clinicians, it also plays other important roles in older adults' health care. The set of criteria is widely used in research and in the training of healthcare professionals. The Beers Criteria also informs quality measures. Organizations and agencies such as the National Committee for Quality Assurance (NCQA), the Pharmacy Quality Alliance, and the Centers for Medicare and Medicaid Services (CMS) have relied on the criteria when developing quality measures addressing the pharmacological care of older adults. CMS has also incorporated the Beers Criteria into Medicare Part D policy and uses it to evaluate nursing home adherence to medication-related regulations. In 2011, the American Geriatrics Society (AGS) sponsored an update of the criteria, assembling a panel of 11 experts in geriatrics and pharmacology who used an enhanced, evidence-based methodology to develop the 2012 Beers Criteria. This new edition of the criteria appears in this issue of the *Journal of the American Geriatrics Society*.

Improving the quality of care for all older adults has been the mission of the AGS since its founding in 1942. In light of this, it is only appropriate that the society take a leading role in updating the criteria. Improving prescribing for older adults has long been a focus of the AGS annual scientific meetings, research conferences, clinical practice guidelines, and educational programs and tools, as well as numerous articles in this journal and AGS's other journals: *Clinical Geriatrics*, *Annals of Long-Term Care*, and *The American Journal of Geriatric Pharmacotherapy*. It has also been a focus of the society's public policy advocacy work. AGS leaders, members, and staff regularly meet with lawmakers and their staff to discuss issues concerning health care for older adults—including appropriate and safe prescribing. Society leaders have been invited to testify before the Senate Select Committee on Aging regarding this and other subjects. The AGS is also active in quality measure review and development and works with organizations such as the NCQA to ensure that quality measures concerning pharmacotherapy and other elements of care take into account the needs of all older adults, including the most complex and vulnerable.

The new, 2012 Beers Criteria differs from earlier editions in a number of ways. Medications that are no longer available have been removed, and drugs introduced since 2003 have been added. Research on drugs included in earlier versions is updated, and new information is provided about appropriate prescribing of medications for an expanded list of common geriatric conditions. In updating the Beers Criteria, the interdisciplinary panel followed an evidence-based approach that the Institute of Medicine recommended in its 2011 report on developing practice guidelines. The new criteria also include ratings of the quality of the evidence supporting the panel's recommendations and the panel's assessment of the strength of these recommendations.

Although the criteria provide invaluable information regarding prescribing for older patients, there are important caveats concerning their use. As the panelists emphasize, the Beers Criteria should not substitute for professional judgment or dictate prescribing for an individual patient. That would be at odds with the principles of geriatrics, which call for tailoring care to each patient's individual needs, circumstances, and wishes. The criteria, the panel points out, are not applicable in all circumstances. Among other things, they do not address the needs of individuals receiving palliative and hospice care. For example, a clinician prescribing for an individual receiving end-of-life care might determine that a medication in Table 2 of the criteria—a table listing medications that are potentially inappropriate for older adults—is the *only* reasonable choice for that individual, but in this and other

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cases in which Table 2 medications appear to be the best choice for a given individual, the criteria may play a supplementary role by highlighting potential side effects. The panelists add, "If a provider is not able to find an alternative and chooses to continue to use a drug on this list in an individual patient, designation of the medication as potentially inappropriate can serve as a reminder for close monitoring so that [adverse drug effects] can be incorporated into the electronic health record and prevented or detected early."[1]

Just as the criteria should not dictate prescribing, they should not be the sole basis for formulary decisions, nor should they be used in any punitive manner, the panelists emphasize. We agree strongly. Rather, the role of the 2012 Beers Criteria should be to *inform* clinical decision-making, research, training, and policy to improve the quality and safety of prescribing medications for older adults.

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REFERENCE

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