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The 2019 Beers Criteria: What You Need to Know

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The Beers Criteria[1] may well be one of the best-kept secrets in geriatrics. While widely cited in prescribing guidelines for older adults, some geriatricians, at least anecdotally, report that many primary care physicians either don't know about them or don't use them, even though 90% of older adults take at least one prescription drug.[2] And about one third of these older patients have been prescribed at least one drug on the Beers Criteria warning list.[3]

The Beers Criteria do more than guide decisions about what drugs to use in older patients. They also tell us what *not* to do—that is, what drugs are potentially good candidates for deprescribing.[4]

Issued by the American Geriatrics Society (AGS), the latest version of the Beers Criteria was released in January 2019. These updated criteria, which apply to all clinical settings except hospice and palliative care, list 30 individual medications or medication classes to be avoided. The criteria list more than 40 additional drugs or drug classes that should be used with caution or avoided altogether in certain diseases or conditions.

Medscape spoke with Michael A. Steinman, MD, co-chair of the AGS committee, about these updates and their implications.

What's Changed?

The 2019 update drops 25 medications or medication classes included in earlier versions because they are no longer available in the United States or because concerns with the drugs are not limited to the older population alone.

Otherwise, the new recommendations do not differ extensively from those of 2015.[5] "That reflects the stability of our recommendations and a maturity in the evidence for many of the drugs," Steinman contended. He did caution, however, that "the literature isn't as robust as we would like for some of these medications."

The rationale for each recommendation, the quality of supporting evidence, and the graded strength of the recommendation are clearly noted. For example, the criteria list 15 first-generation antihistamines as drugs to avoid, noting, among other reasons, that they are highly anticholinergic and that clearance is reduced with advanced age. While the quality of evidence is determined to be moderate, the Beers committee grades the recommendation as strong. Another example: proton-pump inhibitors. These drugs are associated with a risk for *Clostridium difficile* infection as well as bone loss; evidence is high. But the strong recommendation to avoid is more nuanced, noting that scheduled use for more than 8 weeks should be avoided except for certain high-risk patients.

However, the Beers Criteria are not intended to be taken as gospel. In an accompanying editorial,[6] Steinman and his AGS panel co-chair Donna Fick, PhD, RN, caution against strict adherence to the criteria without considering individual patient circumstances.

In practice, the quality of the evidence is probably not the primary driver of clinician decision-making, Steinman believes. "It's a question of doing the best with the evidence that is out there. The vast majority of recommendations in most guidelines do not have a strong evidence base to support them."

Keeping the Focus Where It Belongs

The Beers Criteria do not include medications that could be a problem for patients of all ages, instead keeping their focus on those that create special concerns in the elderly. "We wanted to emphasize that the harms and benefits of drugs can change as people age," Steinman stressed. "Clinicians may not fully appreciate the additional risks that come with age as well as the changing opportunity for benefit."

The Beers authors stress that the criteria should not be used to excessively restrict access to these medications.

He outlined some of the challenges faced in deciding which drugs to retain in the updated criteria, noting that "some medications were removed not because their benefits and risks have changed, but because these drugs were only rarely used. We wanted to declutter the criteria and ensure that people weren't overwhelmed." Instead, the focus is on more frequently prescribed drugs—though "how you determine that is not always easy," he admitted.

What's Missing in the 2019 Update

Statins. A widely used drug class that some might have expected to see in the Beers Criteria is absent. Studies of statins for primary prevention of cardiovascular disease have reached different conclusions about benefit in people over 65, and major guidelines in North America and Europe differ in their recommendations for the use of statins in older adults.[7] Recent reviews found little or no benefit in the very elderly,[8,9] and the latest US cholesterol management guidelines advise that statins may have limited benefit in adults aged ≥ 75 years with physical or cognitive functional decline, comorbidities, or frailty.[10] "Concerns have been raised about the role of statins, particularly in primary prevention for older adults, but we did not find any very clear evidence for an unambiguous recommendation," Steinman said. Further clarification is expected in 2020, when the STAREE (Statins in Reducing Events in the Elderly) trial of atorvastatin versus placebo in individuals aged ≥ 70 years is completed.

Drugs approved in other countries. Also absent from the Beers Criteria are medications not approved in the United States. But that does not mean that they are not useful for clinicians in other countries. "It's a matter of applying common sense," according to Steinman. "For example, a blanket recommendation to avoid benzodiazepines would also apply to benzodiazepines not available here. The principles are the same, even though the specific medications might differ from country to country," he maintained.

The Beers Criteria Should Not Be Overused

The Beers authors stress that the criteria should not be used to excessively restrict access to these medications through policies such as prior authorization and/or health plan coverage policies.[6,11] The American Medical Association (AMA) recently voiced concern that payers may use the Beers Criteria inappropriately to rate quality of care delivered by a physician and determine coverage, potentially financially penalizing physicians. In a 2018 resolution, the AMA emphasized that the Beers Criteria "should not be applied in a punitive or onerous manner to physicians and must recognize that deviations from the quality measure may be appropriate."

Steinman agreed. "We certainly don't want the criteria to be used to restrict access for people and penalize them." There will still be individual patients who can appropriately be prescribed drugs that warrant caution.

Access to the Beers Criteria

The 2019 AGS Beers Criteria document is available free to AGS members and to subscribers of the *Journal of the American Geriatrics Society,* but nonmembers must pay ($42.00 currently) to download a printable version. The AGS and Steinman declined to comment on why the paper is not available free of charge to everyone. The 2019 criteria can also be accessed for a fee via the AGS iGeriatrics smartphone app ($9.99/year for all subscribers). The AGS has entered into a 15-year license agreement with Clinical Support Information Systems to incorporate the Beers Criteria into medication review solution software.

A summary of the Beers Criteria for patients is available free on the website of the AGS's Health in Aging Foundation, along with tip sheets in English and Spanish and what patients can do if they find that they are taking a medication on the list. The AGS believes that the criteria provide a useful tool for initiating conversations between

patients and healthcare providers about the effectiveness, adverse effects, cost, adherence, and goals of care for patients' entire medication regimens.

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