POLICY STATEMENT

American Medical Directors Association
and
American Society of Consultant Pharmacists

Joint Position Statement

on the Beers List of Potentially Inappropriate Medications in Older Adults

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Background

Publication of “Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults” (1) again raises many of the same issues about the list’s development and uses—intended and unintentional—since its original publication in 1991 and subsequent 1997 revision (2, 3)

The list was adopted nearly verbatim in the CMS surveyor guidance for Federal Tags F329 and 429, in effect codifying it with the power of federal regulation, although Dr. Beers himself has denied that this was ever the intention of publishing the list. AMDA and other stakeholders have previously questioned the wisdom of including any "checklist" of medications as part of regulations. (4,5,6,7)

The 2003 update sought to improve the list by focusing on drugs and drug-disease combinations, in particular

1. addressing new products or product information,
2. changing severity ratings, and
3. Identifying new conditions.
The results: 11 medications/medication classes were eliminated, 4 were modified, 25 new medications/medication classes independent of diagnoses and 19 medications/medication classes considering diagnoses were added as potentially inappropriate. (1)

A serious reservation about the original list and its latest revision remains: the list is not based on an evidence-based methodology. Instead, the authors again reviewed the geriatric pharmacology literature to develop statements concerning clinical prescribing for older adults. Then a small panel of 12 experts reviewed these statements and rendered their opinions about the appropriateness of prescribing under the described clinical scenarios. They addressed whether a medication/medication class “should generally be avoided in persons 65 years or older because they are either ineffective or they pose unnecessarily high risk for older persons and a safer alternative is available”; and “medications that should not be used in older persons known to have specific medical conditions.”(1) There were no exceptions for palliative care or cases of severe chronic disease. While this methodology offers useful general guidelines for inappropriate prescribing, its lack of a recognized evidence-based methodology limits its applicability.

While the list clearly addresses potential problematic prescribing for older adults and has been used constructively by many, persons without adequate clinical expertise may use the list inappropriately as an absolute prohibition against prescribing certain medications. Ironically, this approach can potentially cause errors that would undermine the intent of the surveyor guidance that includes the list.

ASCP and AMDA believe:

- The Beers list is a helpful general guide regarding potentially inappropriate medication use of medications for older adults, but it must be used in conjunction with a patient-centered care process.
- Ultimately, decisions about medication prescribing must be clinically based and consider the patient's total clinical picture, including the entire medication regimen, history of medication use, comorbidities, functional status, and prognosis.
- Checklist approaches should not substitute for the necessary steps in the care process for appropriate prescribing.
- The Beers list should be used as a general guide for assessing the potential appropriateness of medications, not as an isolated justification for any recommendation, including discontinuation of a medication.

ASCP and AMDA endorse the following principles for appropriate medication prescribing and management for older adults:

Decisions about prescriptions must be (4):

1. evidence-based,
2. made in the context of the patient's entire medical and psychosocial condition, prognosis, quality of life and patient's or surrogate's wishes,
3. made in conjunction with a qualified prescriber with first-person knowledge of the individual patient’s complete clinical profile and history; not withstanding emergency medical coverage,
4. made in the context that overuse, under use and inappropriate use of medications are equally important quality of care concerns, and
5. made without improper use or disclosure of confidential, individual protected medical information that is not necessary for direct patient care.

In addition, medication management in older adults should include these steps (5):
1. Identifying the presence and nature of the resident’s symptom, disease, condition, impairment, or risk.
2. Assessing the resident to identify the cause of the problem, or document why an assessment was not performed.
3. Gathering and assessing information about the resident’s current medications and treatments as well as responses and adverse reactions to previous medications and treatments.
4. Identifying and documenting the reason(s) why the disease, condition, symptom, or impairment needs to be treated or why it is decided not to provide treatment.
5. Choosing an appropriate medication or modifying an existing drug regimen.
6. Identifying and documenting the objective(s) of treatment.
9. Ordering the selected agent.
10. Ordering appropriate precautions in administering the drug, including instructions for resident monitoring.
11. Assessing and documenting the resident’s status during or at the end of treatment.
12. Assessing the resident for possible adverse drug reactions (ADRs).
13. Modifying the medication regimen as indicated by its effectiveness or by the presence of complications.

In conclusion, practitioners who understand the principles underlying the proper prescribing and management of medications in nursing facilities should be better able to apply these principles in providing patient-centered care. Consultant pharmacists and medical directors should collaborate with facility staff to ensure appropriate interpretation and use of any guidelines on medication use, including those from the Centers for Medicare & Medicaid Services (CMS).

References:

* Footnotes:
* Approved by the Board of Directors of the American Medical Directors Association
* Approved by the Board of Directors of the American Society of Consultant Pharmacists, November 2, 2004.