Medications & Older Adults
–
Practical Use of the Beer's Criteria
NW Geriatric Lecture Series

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About Me!

CERTIFIED ashp Well-Being Champion AMBASSADOR

Plein Center for Aging

Plein Center for Aging

About

The Plein Center for Aging is a global leader in transformative pharmacy research, education and outreach. We are committed to optimizing older adults' medication outcomes and promoting healthy aging.

Student/Preceptor Opportunities

The Plein Certificate in Geriatric Pharmacy - The Plein Certificate in Geriatric Pharmacy is meant to train pharmacists to meet the needs of older adults in all practice settings.

Plein Scholars Program - The Plein Scholars program is an opportunity for students to engage in aging-related research with a faculty/preceptor mentor.

Events for All

- **Research Symposium:** Annual event held in Spring showcasing cutting-edge research to improve medication use in older adults.
- **ICYMI Public Lecture:** Annual event held in Fall that features brief presentations on high-profile research relevant to aging. Designed to empower older adults and engage healthcare professionals by translating current findings into accessible insights.

Check out our website for more details!

Disclosure

> Rachel Firebaugh does not have relevant financial relationships with ineligible companies and has no actual or potential conflict of interest in relation to this program/presentation.

> None of the planners for this activity have relevant financial relationships with ineligible companies to disclose.

Overview – Where are We Headed?

- **Background & Intro**
  - 4Ms Framework of an Age-Friendly Health System
  - Beers Criteria®
- **Beers Criteria® - What's New in 2025?**
- **Case: Practical Use of the AGS Beers Criteria® Alternatives List**

Objectives

- **Identify how 'medications' fit into the *4Ms Framework of an Age-Friendly Health System* and utilize this to support focused listening in patient care**
- **Describe the AGS Beers Criteria® including the purpose, use, and newest updates (AGS Beers Criteria® Alternatives List)**
- **Apply the AGS Beers Criteria®, with a specific focus on the most recent updates, to real world practice with older adults**

BIG HOPE #1 --> Practical Information For Practice!

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BIG HOPE #2 → Connection!

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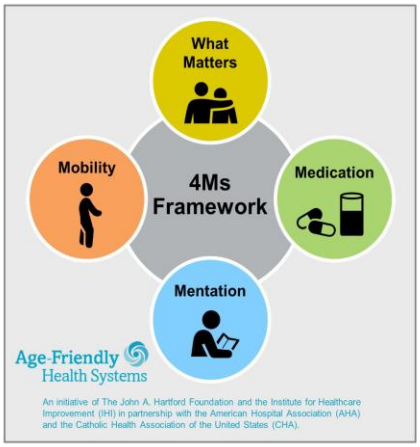
Background: Medications & Age-Friendly Care[1]



What Matters
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Medication
If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation
Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

Mobility
Ensure that older adults move safely every day in order to maintain function and do What Matters.

AGE-FRIENDLY PHARMACIST

https://www.ascp.com/page/agefriendly

Background: Beers Criteria® History[2]

- **First developed in 1991 by Mark H. Beers, MD**
- **Purpose:**
  - decrease inappropriate prescribing and adverse drug events (ADEs)
  - to identify medications or medication classes that should be avoided in older adults in nursing homes

Background: Beers Criteria® Timeline[2,3,4]

- **2011:** After Beers's death, the *American Geriatrics Society* (AGS) began to oversee the revisions and updates to the criteria.
- **2012:** AGS began providing updates to the criteria every 3 years, starting in 2012.
- **2023:** The most recent full update to the criteria was published.
- **In 2025:** Alternatives List came out - this was not a revision of the core Beers Criteria®, but instead a companion resource.

AGS Geriatrics Healthcare Professionals

Leading Change. Improving Care for Older Adults.

So....A Quick Summary, What's Current?

Component	Most Recent Version
Criteria List	2023
Alternatives Guidance	2025
Current Clinical Standard	2023 Criteria + 2025 Alternatives List

Beers Criteria®: What Is It?[2,3]

- **Primary target audience** – practicing clinicians!
- **Intention for Use**: in 65 years and older -- ambulatory, acute, and institutionalized settings of care, except for hospice and palliative
- **Aims:**
  - improve medication selection
  - educate clinicians and patients
  - reduce ADEs
  - serve as a tool for evaluating care, cost, and patterns of medication use of older adults

Beers Criteria® – How Can We Think About?

Beers Criteria®: How's it Organized?[3]

The 2023 AGS Beers Criteria contains 7 tables:

- **Summary of Tables --** Table 1 provides a summary of the recommendations and strength of evidence. Tables 2 through 7 are the primary clinical tables used in practice

Beers Criteria®: How's it Organized?[3]

The 2023 AGS Beers Criteria® contains 7 tables, where do you look for what?:

Table #	Title	Purpose	What it Helps Clinicians Do
1	Quality and strength of evidence	Ground the criteria in evidence from literature	Helps clinicians understand the strength of evidence behind the different recommendations
2	Potentially Inappropriate Medications (PIMs) to Avoid in Older Adults	Lists medications that generally should be avoided in adults ≥65	Identify unsafe medications regardless of disease state
3	Drug–Disease or Drug–Syndrome Interactions	Lists medications that worsen specific conditions	Avoid medications that exacerbate diseases like dementia, falls, heart failure
4	Medications to Use with Caution	Lists medications requiring careful monitoring	Use clinical judgment and monitor for adverse effects

Beers Criteria®: How's it Organized?[3]

The 2023 AGS Beers Criteria® contains 7 tables, where do you look for what?:

Table #	Title	Purpose	What it Helps Clinicians Do
5	Potentially inappropriate drug-drug interactions	Lists combinations that increase risk of serious harm	Prevent dangerous drug combinations
6	Medications whose dosages should be adjusted based on renal function	Lists medications based on kidney function (CrCl)	Adjust doses or avoid drugs in renal impairment
7	Medications with Strong Anticholinergic Properties	Lists drugs with high anticholinergic burden	Reduce risk of confusion, delirium, falls, and cognitive decline

What's New In 2025?[5]

The 2025 AGS *Alternatives Guidance*

"We really took a step back and asked, 'Where are clinicians likely to run into challenges with the Beers Criteria®—and where would having clear alternatives be most helpful…. the expert panel focused on the medications that we thought would be most helpful to provide alternatives for—making sure we hadn't missed anything important and that our selections truly reflected the needs of those caring for older adults."

Todd P. Semla, MS, PharmD, Co-Chair of the Alternative List Panel and AGS Beers Criteria®

What's New In 2025?[4]

The 2025 AGS Beers Criteria® Alternatives List:

- **Supplemental clinical tool:** designed to help clinicians choose safer medication alternatives when a drug listed in the Beers Criteria is potentially inappropriate.

- **Not a replacement to the 2023 Tables:** instead, it answers the key question:

👉 **"If I shouldn't use a medication, what might I do instead to help that person?"**

What's New In 2025?[4]

The 2025 AGS Beers Criteria® Alternatives List:

- **Tables 1- 5 and are organized by clinical conditions** that medications on the 2023 Beers Criteria are commonly used to treat
- **Conditions included**: 21, while some conditions listed are discrete diseases, many are symptoms or syndromes (e.g. insomnia, pruritus) that have a range of etiologies.

What's New In 2025?[4]

The 2025 AGS Beers Criteria® Alternatives List:

- **The tables are organized by <u>four columns</u>:**
  - **(1)** conditions
  - **(2)** relevant Beers Criteria® medications and associated recommendations
  - **(3)** alternatives to consider
  - (**4**) resources for patients, caregivers, and clinicians

What's New in 2025?[4]

Alternatives List includes 5 key principles:

1. Stopping a potentially inappropriate medication is not the end goal. The goal is to provide non-pharmacologic and/or pharmacologic management that helps people feel better and maintain health, while reducing their risk of medication associated harms.

2. Instead of replacing a potentially inappropriate medication with a "better" one, consider non-pharmacologic strategies where appropriate. Such strategies are more effective and safer than medications for managing common chronic conditions.

3. Understanding the underlying cause(s) of a symptom or condition can help guide therapy.

What's New in 2025?[4]

Alternatives List includes 5 key principles:

4. Potentially inappropriate medications should often be avoided but not always. Clinician judgement, consideration of individual circumstances, and shared decision-making should be used when selecting among treatment options.

5. Make use of resources and supports to aid deprescribing.

How Do We Practically Use the AGS Beers Criteria® Alternatives List?: Let's Explore a Case Together!

Case Part 1 --> Pain

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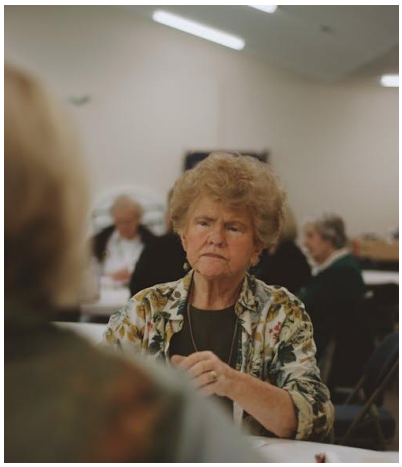
Case Part 1 --> Pain



GG is 77 year old female who is being seen in your clinic for ongoing pain. She tells you she has “noticed more pain and stiffness (3 or 4 most days)” since she stumbled coming out of her apartment a few months ago at her retirement community. She says she was evaluated after that fall and had no fractures. Now she feels more nervous about going to her regular activities, like book club and ‘silver sneakers’ which she says are her “favorites”.

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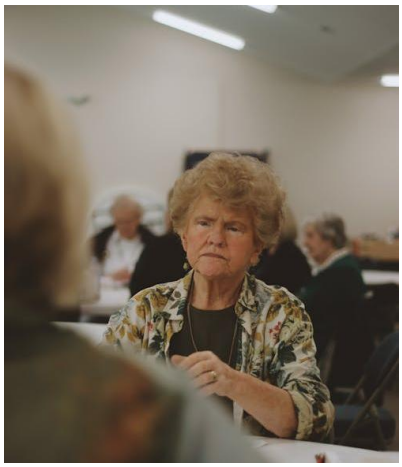
Case Part 1 --> Pain



PMH: Osteoarthritis, GERD, hyperlipidemia, hypertension, anxiety

Allergies: NKA

Medications:
Omeprazole 20 mg daily
Lisinopril 5 mg daily
Simvastatin 20 mg daily
Acetaminophen 500 mg as needed
Ibuprofen 200 mg as needed (she's been taking this more recently)

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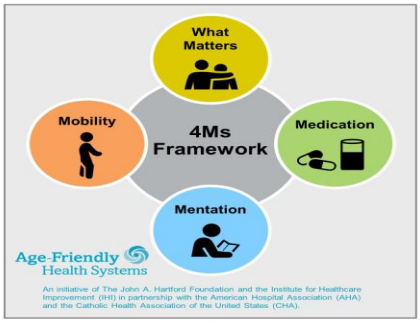
Case Part 1 --> Listening with the '4Ms' in Mind[1]

- **What Matters:** Book club, 'Silver Sneakers' class
- **Medications**: Ibuprofen
- **Mentation**: Staying in = less connection
- **Mobility**: Increased pain & stiffness, nervous to go out



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Case Part 1 –> Beers Criteria® *Alternatives List*[4]

TABLE 1 | (Continued)

Condition	Relevant AGS Beers Criteria® medications	Alternatives to consider (recommendations)	Resources
Pain	Tricyclic antidepressant (TCAs) NSAIDs Meperidine Skeletal muscle relaxants Combination of gabapentinoids with either opioids or benzodiazepines *TCAs recommendation: Avoid* *NSAIDs recommendation: Avoid non-COX-2 selective NSAIDS for chronic use and avoid short-term scheduled use in combination with systemic steroids, anticoagulants, or antiplatelets unless alternatives are ineffective and patient can take a gastroprotective agent (e.g., PPI)* *Meperidine recommendation: Avoid* *Skeletal muscle relaxants recommendation: Avoid*[c] *Combination of gabapentinoids with opioids or benzodiazepines recommendation: Avoid combination (except when cross-tapering opioids and gabapentinoids)*	Use patient-reported outcomes pre- and post- intervention to identify clinically meaningful improvements in pain response to therapeutic options. Improving function should be a key goal in pain management. Consider non-pharmacological approaches for first-line management of chronic pain, alone or in combination with medications. Non-pharmacological options consistently recommended across guidelines for chronic pain vary by the type of pain, and may include the following:[d] – Education interventions – Exercise therapy of any type (e.g., aerobic, aquatic, strengthening, yoga, Tai Chi) – Physical therapy interventions – Needling therapies (e.g., acupuncture) – Psychological interventions (e.g., cognitive behavioral therapy, operant therapy, multicomponent biopsychosocial care, mindfulness-based interventions) – Peripheral electric and/or magnetic stimulation, repetitive transcranial magnetic stimulation (rTMS) Pharmacologic approaches should be targeted to the type of pain (nociceptive, neuropathic).[b,e] For nociceptive pain: Instead of meperidine, choose a different opioid. Instead of skeletal muscle relaxants or long-term use of NSAIDs, consider the following: – Short term use of NSAIDs – Topical NSAIDs (e.g., diclofenac gel) – COX-2 selective inhibitors – Other topical agents, including capsaicin, rubefacients and related agents (e.g., menthol-containing ointments)[f], lidocaine – Acetaminophen – Intra-articular corticosteroids For neuropathic pain: Instead of TCAs, consider the following:[g] – SNRIs – Gabapentinoids[h] – Other topical agents, including capsaicin, rubefacients and related agents (e.g.,	**For patients and caregivers:** Physical activity and self-management education programs for arthritis (CDC) https://www.cdc.gov/arthritis/programs/index.html Resources for pain assessment and management (GeriatricPain.org, U. Iowa) https://geriatricpain.org/ Managing osteoarthritis symptoms (NCOA) https://www.ncoa.org/article/how-seniors-can-manage-osteoarthritis-symptoms Information and resources on physical therapy (APTA) https://www.choosept.com/symptoms-conditions Brochures about risks of and opportunities to deprescribe NSAIDS, chronic opioids, and other medications used for pain (EMPOWER) https://www.deprescribingnetwork.ca/patient-handouts **For clinicians:** Simplified summary, 2022 Canadian PEER chronic pain guideline—see Figure 1 (PEER) https://www.cfp.ca/content/68/3/179#F1 Guidance on deprescribing NSAIDs (Primary Health Tasmania) https://www.primaryhealthtas.com.au/wp-content/uploads/2023/03/A-guide-to-deprescribing-non-steroidal-anti-inflammatory-drugs.pdf

Case Part 1 –> Summary (Possible Approach)[4]

- **Condition:** Pain
- **Relevant AGS Beers Criteria® Medications:**
  NSAID (ibuprofen)
- **Alternatives to Consider (recommendations):**
  - Education
  - Exercise Therapy
  - Physical Therapy
- **Resources:**

Patient →

- *Managing osteoarthritis symptoms (NCOA)* - https://www.ncoa.org/article/how-seniors-can-manage-osteoarthritis-symptoms/
- *Information and Resources on Physical Therapy (APTA)* - https://www.choosept.com/symptoms-conditions

Clinicians →

- *Guidance on deprescribing NSAIDs (Primary Health Tasmania)* - https:// www. prima ryhea lthtas. com. au/ wp- conte nt/ uploa ds/ 2023/ 03/ A- guide - to- depre scrib ing- non- stero idal- anti- infla mmato ry drugs. Pdf

Case Part 1 –> What if You Still Need to Go With A Medication?[4]

- **Condition:** Pain
- **Relevant AGS Beers Criteria® Medications:**
  NSAID (ibuprofen)
- **Alternatives to Consider (recommendations):**

Pharmacologic approaches should be targeted to the type of pain (nociceptive, neuropathic).[b,e]

For nociceptive pain: Instead of meperidine, choose a different opioid. Instead of skeletal muscle relaxants or long-term use of NSAIDs, consider the following:

- Short term use of NSAIDs
- Topical NSAIDs (e.g., diclofenac gel)
- COX-2 selective inhibitors
- Other topical agents, including capsaicin, rubefacients and related agents (e.g., menthol-containing ointments)[f], lidocaine
- Acetaminophen
- Intra-articular corticosteroids

For neuropathic pain: Instead of TCAs, consider the following:[g]

- SNRIs
- Gabapentinoids[h]
- Other topical agents, including capsaicin, rubefacients and related agents (e.g., menthol-containing ointments)[f], lidocaine

Case Part 2 --> Anxiety

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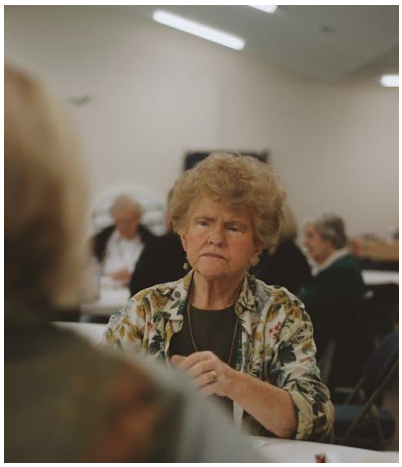
Case Part 2 --> Anxiety



As you talk more, GG seems to be comfortable opening up. She tells you feelings of worry, nervousness, and anxiety are with her consistently throughout the day. Ever since she lost her husband 6 months ago it's been getting worse. He walked with me to all my activities and helped at home with everything. Things just feel harder and more overwhelming. She tells you, "my medications are everywhere". I found some leftover lorazepam in the bathroom and I took a couple this week to get by. "Could you prescribe me some more? I want to feel like myself again."

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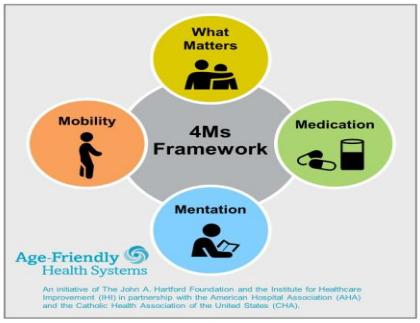
Case Part 2 --> Listening with the '4Ms' in Mind[1]

- **What Matters:** "I want to feel like myself again"
- **Medications**: Lorazepam, disorganized - tells you "medications everywhere"
- **Mentation**: Staying in, lost major support person
- **Mobility**: nervous to go out, husband walked with her



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Case Part 2 –> AGS Beers Criteria®
Alternatives List[4]

TABLE 3 | (Continued)

Condition	Relevant AGS Beers Criteria® medications	Alternatives to consider (recommendations)	Resources
Anxiety symptoms	Benzodiazepines First-generation antihistamines Tricyclic Antidepressants Barbiturates Meprobamate *Recommendation (all): Avoid*	Clarify whether symptoms are related to an underlying psychiatric disorder, e.g., Generalized Anxiety Disorder, Panic Disorder, PTSD. Some anxiety symptoms may be an appropriate response to life events and can be addressed through non-pharmacologic supports until symptoms improve. Evaluate other conditions that may be contributing to anxiety, such as comorbid medical disorders, mental health disorders (e.g., major depression), substance misuse, and medications. This is of special importance for new-onset anxiety, as late-life onset of anxiety disorders is uncommon. Non-pharmacologic interventions are first-line therapy for many psychiatric disorders that present with anxiety. Tailor such treatment to the specific diagnosis; examples of options include individual or group psychotherapy approaches including cognitive behavioral therapy, acceptance and commitment therapy, mindfulness-based stress reduction, and imagery rehearsal therapy (for nightmares). If pharmacologic therapy is indicated, consider agents with a safer adverse effect profile for older adults, including the following. Note that the AGS Beers Criteria® cautions use of SSRIs and SNRIs in older adults with a history of falls, due to increased fall risk:[b] – *Generalized Anxiety Disorder:* escitalopram, sertraline, venlafaxine, duloxetine, buspirone, pregabalin[c] – *Panic Disorder:* sertraline, escitalopram, venlafaxine – *Social Anxiety Disorder:* escitalopram, sertraline, venlafaxine (also: beta-blocker, e.g. propranolol, for performance-only anxiety) – *PTSD, global symptoms:* sertraline, venlafaxine – *PTSD, nightmares:* prazosin	**For patients and caregivers:** Brochure on why and how to stop anti-anxiety medications (EMPOWER) https://www.deprescribingnetwork.ca/patient-handouts Information and resources on anxiety (ADAA) https://adaa.org/ Information and resources on PTSD (VA) https://www.ptsd.va.gov/index.asp Self-help books https://www.abct.org/self-help-book-recommendations/ **For clinicians:** Algorithm for deprescribing benzodiazepines (deprescribing.org) https://deprescribing.org/wp-content/uploads/2019/03/deprescribing_algorithms2019_BZRA_vf-locked.pdf Other resources on deprescribing benzodiazepines (deprescribing.org) https://deprescribing.org/resources/deprescribing-guidelines-algorithms/ Detailed information on tapering benzodiazepines (Ashton) https://www.benzo.org.uk/manual/ Information and resources on PTSD (VA) https://www.healthquality.va.gov/guidelines/mh/ptsd/index.asp

Case Part 2 –> Summary (Possible Approach)[4]

- **Condition:** Anxiety
- **Relevant AGS Beers Criteria® Medications :** Lorazepam
- **Alternatives to Consider (recommendations):**
  - Clarify whether symptoms are related to an underlying psychiatric disorder or if symptoms may be an appropriate response to life events and can be addressed
  - Non-pharmacologic interventions are first line: psychotherapy
- **Resources:**

  Patient →
  - *Self help books* - https://www.abct.org/self-help-book-recommendations/

  Clinicians →
  - *Algorithm for deprescribing benzodiazepines* - https://deprescribing.org/wp-content/uploads/2019/03/deprescribing_algorithms2019_BZRA_vf-locked.pdf

Case Part 2 –> What if You Still Need to Go With A Medication?[4]

- **Condition:** Anxiety
- **Relevant AGS Beer's Criteria Medications:** Lorazepam
- **Alternatives to Consider (recommendations):**

If pharmacologic therapy is indicated, consider agents with a safer adverse effect profile for older adults, including the following. Note that the AGS Beers Criteria® cautions use of SSRIs and SNRIs in older adults with a history of falls, due to increased fall risk:[b]

- *Generalized Anxiety Disorder:* escitalopram, sertraline, venlafaxine, duloxetine, buspirone, pregabalin[c]
- *Panic Disorder:* sertraline, escitalopram, venlafaxine
- *Social Anxiety Disorder:* escitalopram, sertraline, venlafaxine (also: beta-blocker, e.g. propranolol, for performance-only anxiety)
- *PTSD, global symptoms:* sertraline, venlafaxine
- *PTSD, nightmares:* prazosin

Case Part 3 --> Insomnia

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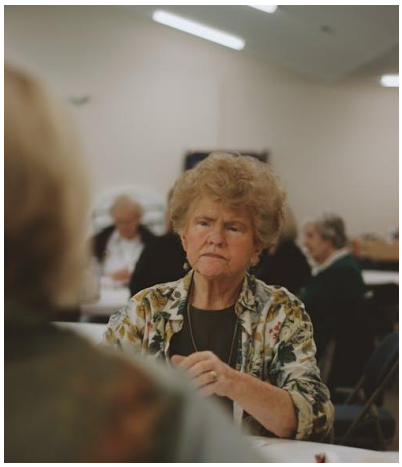
Case Part 3 --> Insomnia



After talking a bit more, tears begin to flow and she says, “I’ve started taking an over-the-counter PM med from CVS so I can shut my mind off at night and sleep.” She brought it with her to show you. She tells you she’s never struggled with sleep until she lost her husband. She pauses and then again says, “I just want to feel like myself again”.

Note: You look at the “PM Med” and its Tylenol with Benadryl

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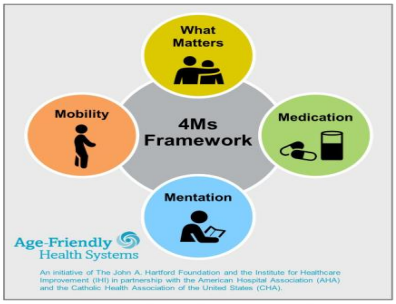
Case Part 3 --> Listening with the ‘4Ms’ in Mind[1]

- **What Matters:** “I want to feel like myself again”
- **Medications**: “PM med” (diphenhydramine/Benadryl with acetaminophen/Tylenol)
- **Mentation**: “PM med” impact on CNS
- **Mobility**: “PM med” impact on CNS



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Case Part 3 –> AGS Beers Criteria® *Alternatives List*[4]

TABLE 3 | Central nervous system and neuropsychiatric conditions in older adults.

Condition	Relevant AGS Beers Criteria® medications	Alternatives to consider (recommendations)	Resources
Insomnia	Benzodiazepines Z-drugs First-generation antihistamines Tricyclic Antidepressants Barbiturates *Recommendation (all): Avoid*	Assess for health conditions and other factors contributing to sleep disruption (e.g., sleep environment, pain, medications or substances which interfere with sleep, obstructive sleep apnea). Cognitive behavioral therapy for insomnia (CBT-I) is first-line treatment for chronic insomnia in older adults. CBT-I may be delivered by a trained provider or via other formats (e.g., digital CBT-I; see Resources column); evidence supports both. Core components of CBT-I include sleep restriction, stimulus control therapy, cognitive therapy, relaxation, and sleep hygiene. However, sleep hygiene alone is not effective for chronic insomnia. If CBT-I alone is unsuccessful, use shared decision-making when considering adding short-term pharmacological therapy. Medications which may be safer (but not completely safe) and have evidence of effectiveness for insomnia in older adults include low-dose doxepin (up to 6 mg), dual orexin receptor antagonists (e.g., daridorexant, lemborexant, suvorexant), and ramelteon, all for short-term use. However, formal, evidence-based guidelines addressing efficacy and/or safety of these medications in older adults are not available. There is insufficient evidence to recommend trazodone, mirtazapine, melatonin, and other medications commonly prescribed for older adults with insomnia disorder. Guidelines do not recommend these drugs for insomnia disorder in adults of any age.	**For patients and caregivers:** Digital CBT-I tools. Examples include: • Insomnia Coach digital CBT-I app (VA), https://mobile.va.gov/app/insomnia-coach • SleepEZ digital CBT-I (VA), https://veterantraining.va.gov/insomnia/ • Curated list of digital CBT-I and other resources (Sleepwell), https://mysleepwell.ca/cbti/sleepwell-recommends/ Sleep hygiene recommendations (as a component of CBT-I) (AASM) https://sleepeducation.org/healthy-sleep/healthy-sleep-habits/ Self-help books for insomnia (see footnote)[a] **For clinicians:** Insomnia toolkit for clinicians (AASM) https://aasm.org/clinical-resources/insomnia-toolkit/ Sleep education resources (AASM) https://sleepeducation.org/resources-for-health-care-professionals/ CBT-I provider training online course (CBTIweb) https://cbtiweb.org/

Case Part 3 –> Summary (Possible Approach)[4]

- **Condition:** Insomnia
- **Relevant AGS Beers Criteria® Medications: "**PM med", First Generation Antihistamine (diphenhydramine/Benadryl with acetaminophen/Tylenol)
- **Alternatives to Consider (recommendations):**
  - Assess for health conditions and other factors contributing to sleep disruption
  - Cognitive behavioral therapy for insomnia (CBT- I) is first- line treatment for chronic insomnia in older adults. CBT- I may be delivered by a trained provider or via other formats (e.g., digital CBT- I; see Resources column); evidence supports both
- **Resources**

  Patient →
  - *Sleep hygiene recommendations (as a component of CBT- I)* - (AASM) https:// sleep educa tion. org/ healt hy sleep/ healt hy sleep habits/

  Clinicians →
  - *Insomnia toolkit for clinicians (AASM*) - https:// aasm. org/ clini cal resou rces/ insom nia toolk it/

Case Part 3 –> What if You Still Need to Go With A Medication?[4]

- **Condition:** Insomnia
- **Relevant AGS Beer's Criteria Medications: "**PM med", First Generation Antihistamine (diphenhydramine/Benadryl with acetaminophen/Tylenol)
- **Alternatives to Consider (recommendations):**

If CBT-I alone is unsuccessful, use shared decision-making when considering adding short-term pharmacological therapy.

Medications which may be safer (but not completely safe) and have evidence of effectiveness for insomnia in older adults include low-dose doxepin (up to 6 mg), dual orexin receptor antagonists (e.g., daridorexant, lemborexant, suvorexant), and ramelteon, all for short-term use. However, formal, evidence-based guidelines addressing efficacy and/or safety of these medications in older adults are not available.

There is insufficient evidence to recommend trazodone, mirtazapine, melatonin, and other medications commonly prescribed for older adults with insomnia disorder. Guidelines do not recommend these drugs for insomnia disorder in adults of any age.

Case – Pulling It All Together!

- **Instead of…**
  - NSAID for pain
  - Lorazepam for anxiety
  - "PM Med" (Tylenol with Benadryl) for sleep

Case – Pulling It All Together! (cont.)

- **Support Patient with Guidance of The 2025 AGS Beers Criteria® Alternatives List & Clinical Judgement (Recommendations):**
  - Education
  - Physical Therapy (possibly OT in the future)
  - Psychotherapy (CBT)
  - Short term pharmacotherapy if needed/desired
    - **Pain** – short term oral NSAID or topical NSAID
    - **Anxiety** – depends on behavior health evaluation
    - **Sleep** - therapy needs to meet sleep issue
  - Direct patient to applicable resources
  - FOR YOU = utilize provider resources

Key Takeaways – What Does this Mean for Me & Our Team?

- **Providing patient care for older adults is complex and especially the approach to medications can be difficult - building a trusted relationship is key.**
- **The 4Ms help provide a supportive lens for listening and making shared decisions when it comes to medications.**
- **Beer's Criteria can leave us feeling stuck and without options for our patients!**
- **SO…utilize *The 2025 AGS Beers Criteria® Alternatives List for recommendations of what you CAN DO* + resources for patients/caregivers PLUS YOU!**

How Can We Support Use of the AGS Beers Criteria® Alternatives List in Our Care Settings?

Let's Brainstorm Together!:

- Technology
- Education
- Collaboration
- Patients
- Others???

We each bring strengths and valuable insights that can make a difference for older adults in our communities and settings!

References

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Questions?

Feel welcome to reach out to me directly – I would love to hear from you!

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