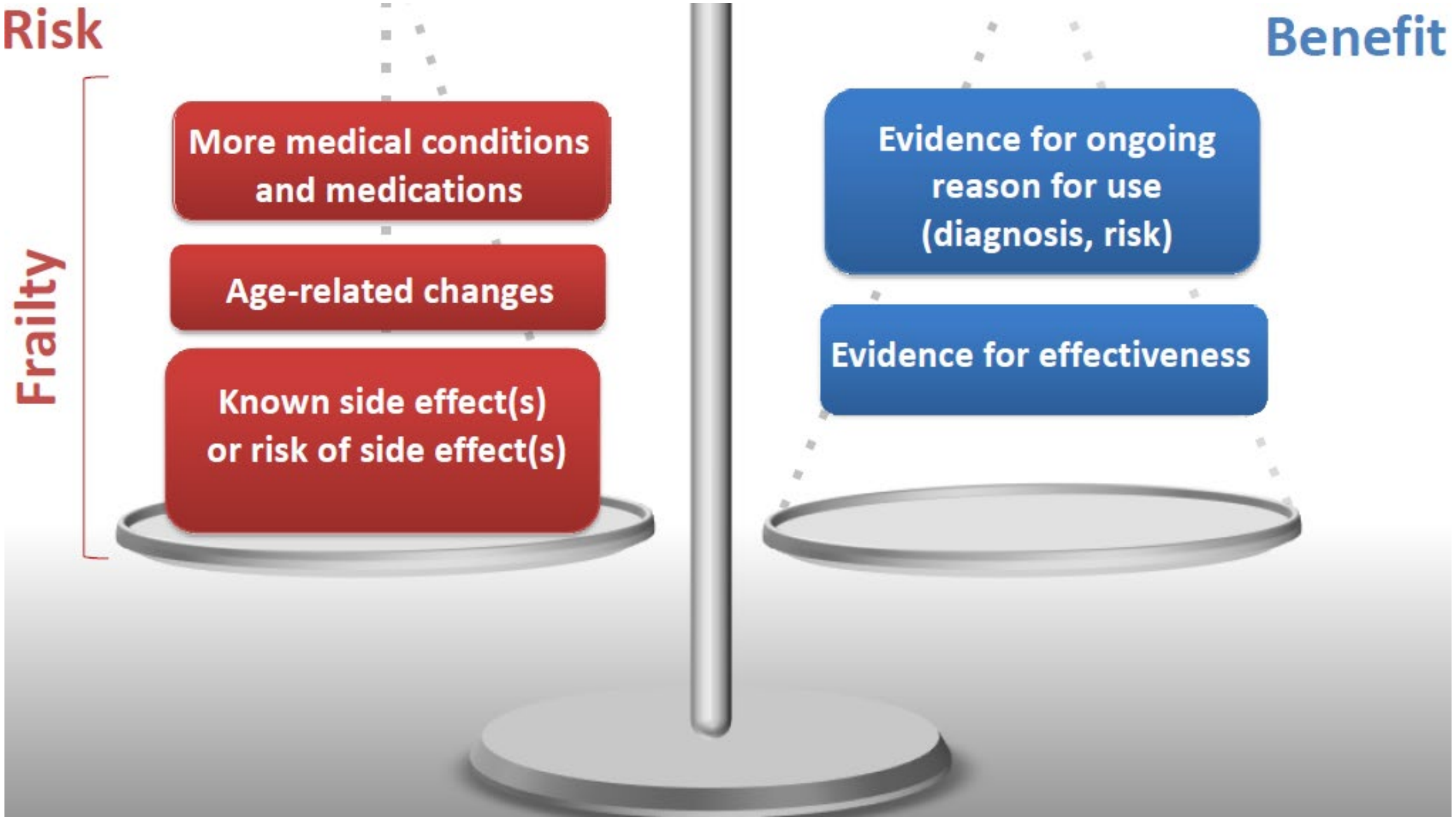
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH) & Concurrent Use of Opioids and Benzodiazepines (COB)

QUALITY SPOTLIGHT: 2026


Risk
Benefit
Frailty
More medical conditions and medications
Age-related changes
Known side effect(s) or risk of side effect(s)
Evidence for ongoing reason for use (diagnosis, risk)
Evidence for effectiveness

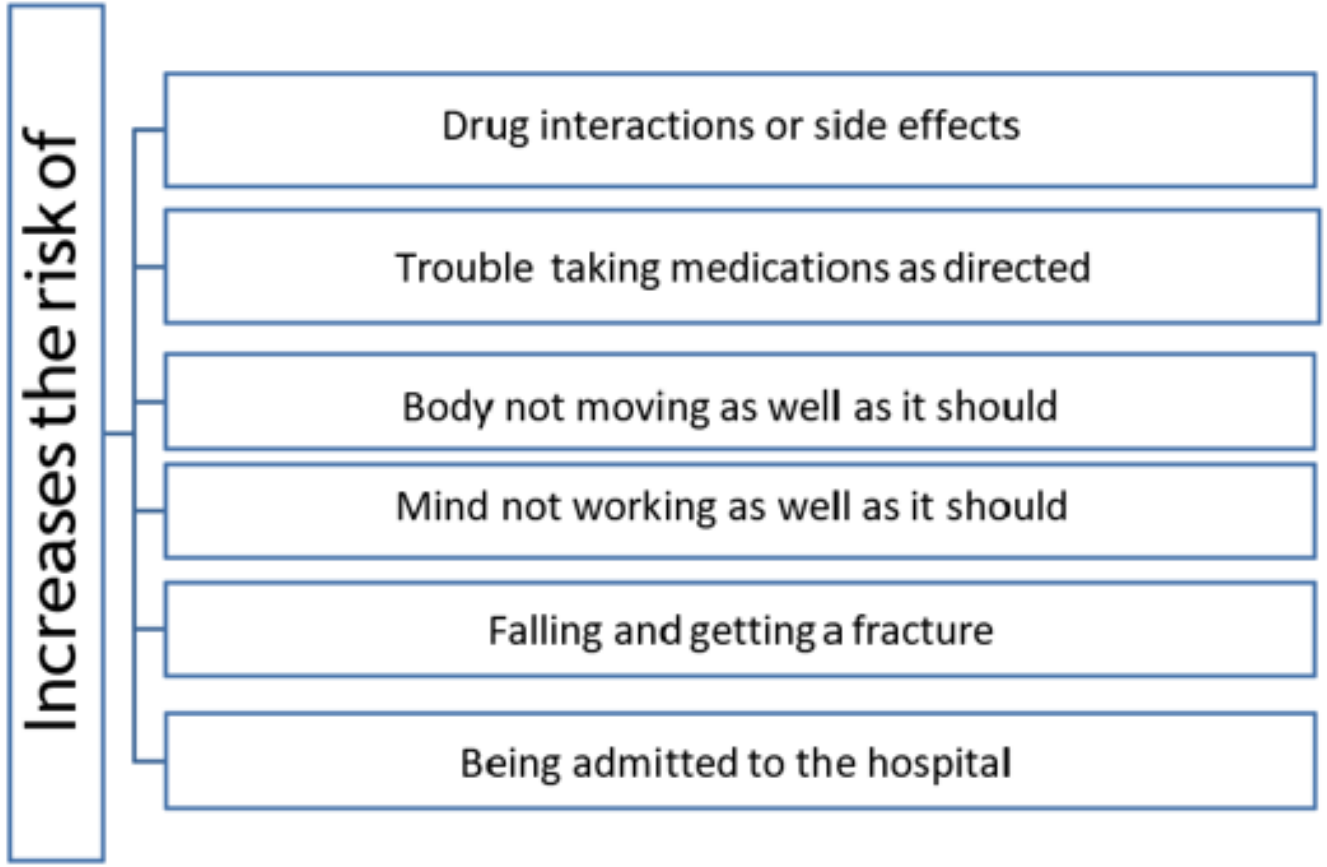
Do You Know the “Why” of Deprescribing These Medications?

Anticholinergics have also been associated with increased **risk of dementia**

Anticholinergics may cause **cognitive disorder symptoms** which may be **mistaken as normal manifestations of aging**

Long-term continued use of anticholinergics **could induce brain changes partially comparable to those present in Alzheimer’s**

Polypharmacy Can Lead to Various Patient Concerns

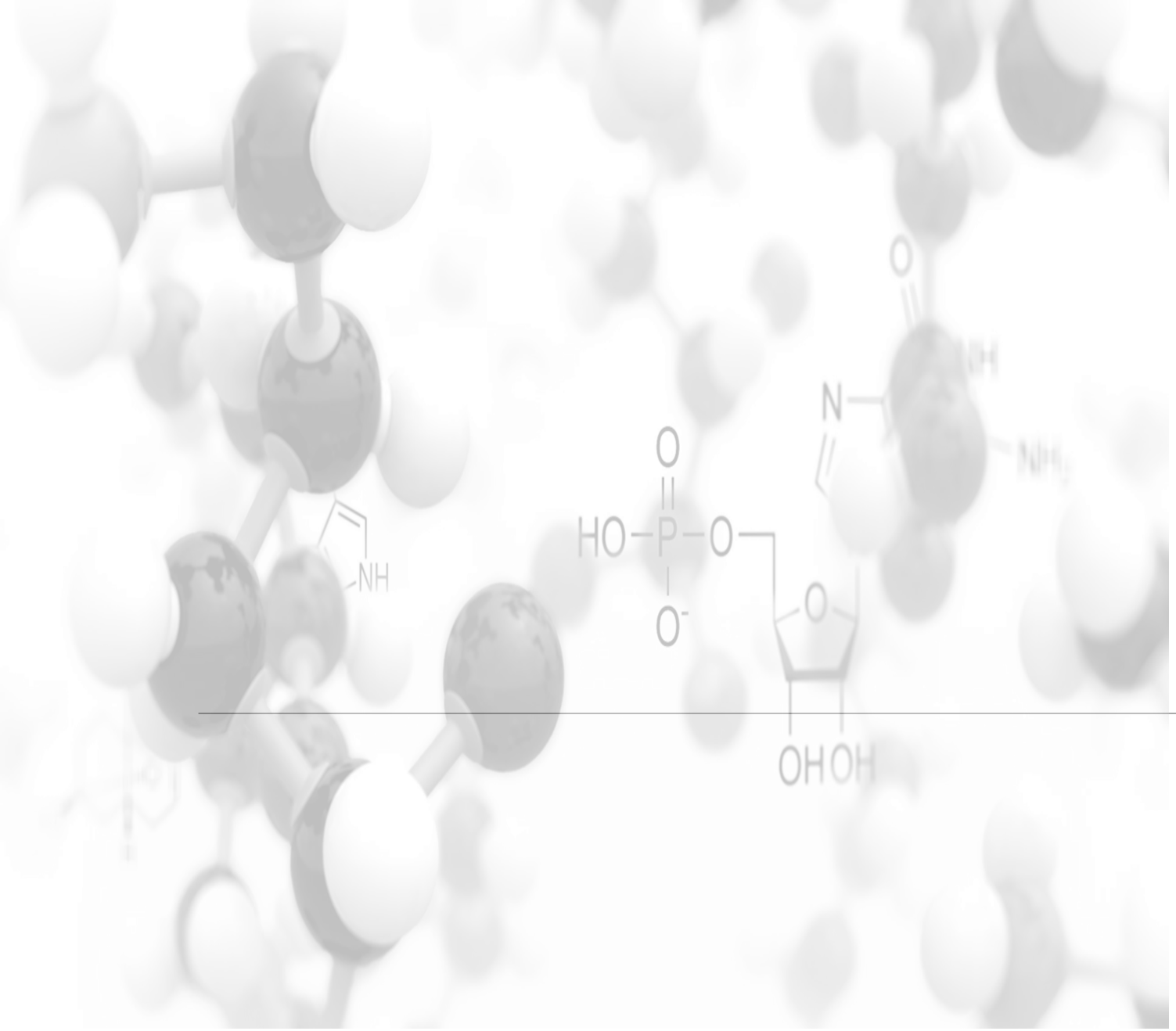


Common Symptoms or Problems Caused by These Medications

Symptom or problem	Medication-related causes or contributors[1–8]
Confusion or cognitive impairment or sedation	Anticholinergics, anticonvulsants (including gabapentinoids), antidepressants (e.g., TCAs, trazodone, low dose mirtazapine), antipsychotics, benzodiazepines and Z drugs, sedating antihistamines, opioids
Constipation	Anticholinergics, opioids, TCAs, calcium channel blockers, calcium and iron supplements
Diarrhea	Antibiotics, antipsychotics, benzodiazepines and Z drugs, GLP1-RAs, metformin, proton pump inhibitors, SSRIs
Peripheral edema	Amlodipine, atypical antipsychotics, dopamine agonists, estrogens, gabapentinoids, insulin, mineralocorticoids, nitrates, NSAIDs
Falls	Anticholinergics, anticonvulsants, antidepressants, antihyperglycemics (e.g., sulfonylureas, insulin), antihypertensives, antipsychotics, benzodiazepines and Z drugs, opioids, sedating antihistamines
Insomnia	Caffeine, corticosteroids, beta-blockers, oral decongestants, stimulants, stimulating antidepressants (e.g., bupropion, SSRIs, SNRIs)
Urinary incontinence	Acetylcholinesterase inhibitors, alpha blockers, anticholinergics, antidepressants, antipsychotics, benzodiazepine and Z drugs, diuretics, SGLT2i, opioids

GLP1-RA = glucagon-like peptide-1 receptor agonist; NSAID = nonsteroidal anti-inflammatory drug; SGLT2i = sodium-glucose cotransporter-2 inhibitor; SNRI = serotonin-norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant; Z drug = nonbenzodiazepine hypnotic.

[a] Examples only, not an exhaustive list.



Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults (POLY-ACH)

QUALITY SPOTLIGHT 2026

The Percentage of Patients with Concurrent Use of Two or More Unique Anticholinergic Medications

POLY-ACH

Denominator:

Patients ≥ **65 years** and older with **two or more** prescriptions filled for the **same anticholinergic** medication on **different dates of service** during measurement year

Numerator:

Patients with **concurrent use** of **two or more unique anticholinergic** medications filled for **at least a 30-day** supply on **different dates of service**

What Does This Mean?

If you have a patient on any 2 of these anticholinergic medications for over 30 days anytime during the year it will not meet the metric.

One longer term medication and one short term (ie; 1–2-week duration) meets the metric.

One long term medication and another longer-term medication (Over 30 days worth) **does not meet** the metric.

Antidepressant Medications

- amitriptyline
- amoxapine
- clomipramine
- desipramine
- doxepin (>6 mg/day)
- imipramine
- nortriptyline
- paroxetine

Antihistamine Medications

- brompheniramine
- chlorpheniramine
- cyproheptadine
- dimenhydrinate
- diphenhydramine (oral)
- doxylamine
- hydroxyzine
- meclizine
- triprolidine

Antiparkinsonian Agent Medications

- benztropine
- trihexyphenidyl

Antispasmodic Medications

- atropine (excludes ophthalmic)
- clidinium-chlordiazepoxide
- dicyclomine
- homatropine (excludes ophthalmic)
- hyoscyamine
- scopolamine (excludes ophthalmic)

Antiemetic Medications

- prochlorperazine
- promethazine

Antimuscarinic Medications (urinary incontinence)

- darifenacin
- fesoterodine
- flavoxate
- oxybutynin
- solifenacin
- tolterodine
- trospium

Antipsychotic Medications

- chlorpromazine
- clozapine
- olanzapine
- perphenazine

Skeletal Muscle Relaxant

- cyclobenzaprine
- orphenadrine

Exclusions

Received hospice services anytime during the measurement year

Helpful Hints

Avoid the use of anticholinergic medications in older adults without first considering safer alternatives or non-drug measures

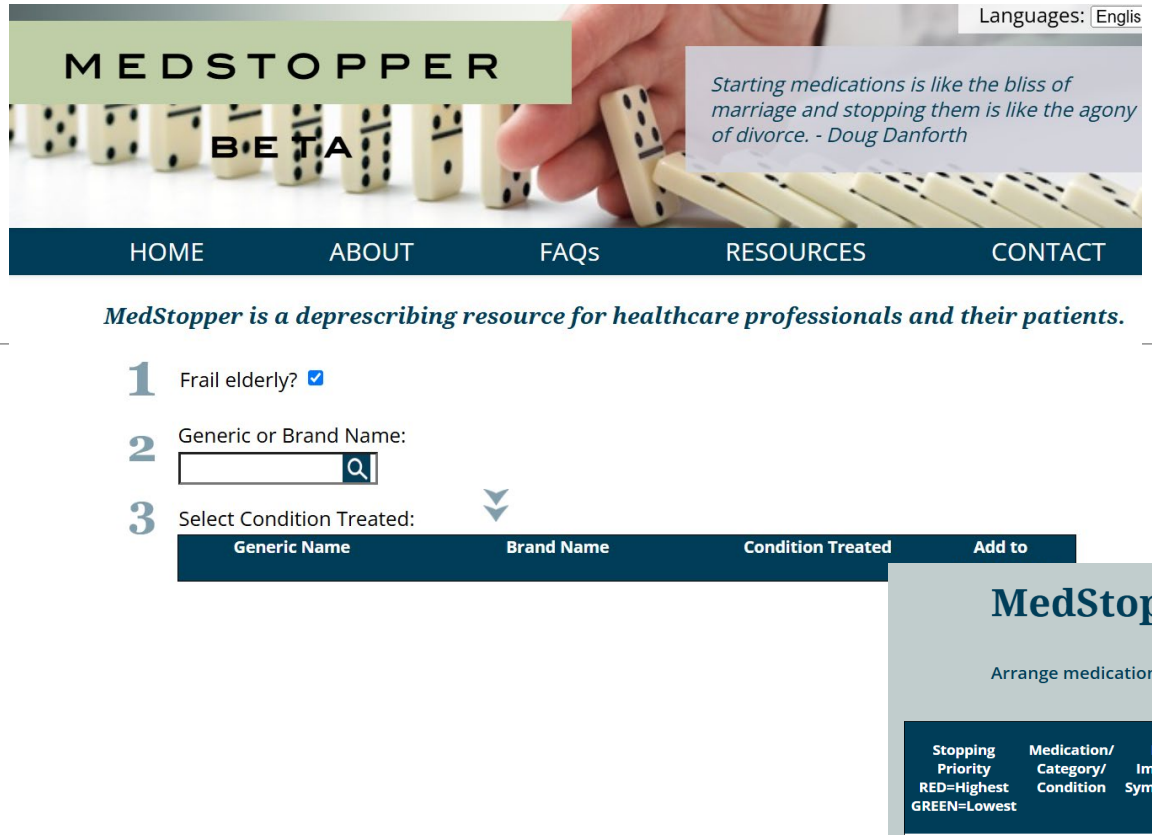
Assess for side effects including confusion, dry mouth, blurry vision, constipation, urinary retention, decreased perspiration, and excess sedation

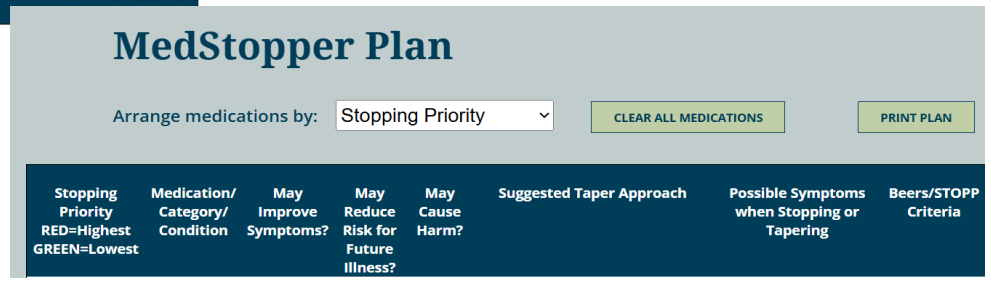
Discuss risks and side effects of anticholinergic medications

- Explain why, as they age, it is imperative to remove some of these medications. Even if they have been taking them for years.
- Share patient stories of success.
- Ask patients to choose one of the medications to wean, they likely know which one they could do without. Has proven successful with other patients.
- Work with patients in shared decision making.
- Remember, patients are extremely apprehensive, support them with your care manager or care coordinator checking on them frequently.

Continue long-term co-prescribing only when necessary and monitor closely

Resources





https://medstopper.com/

Https://deprescribing.org/resources/deprescribing-guidelines-algorithms/

https://deprescribing.org/resources/5-tips-to-manage-polypharmacy/

Pharmacy Quality Alliance (PQA). 2024. “PQA Quality Measures.”https://www.pqa.org/measures/

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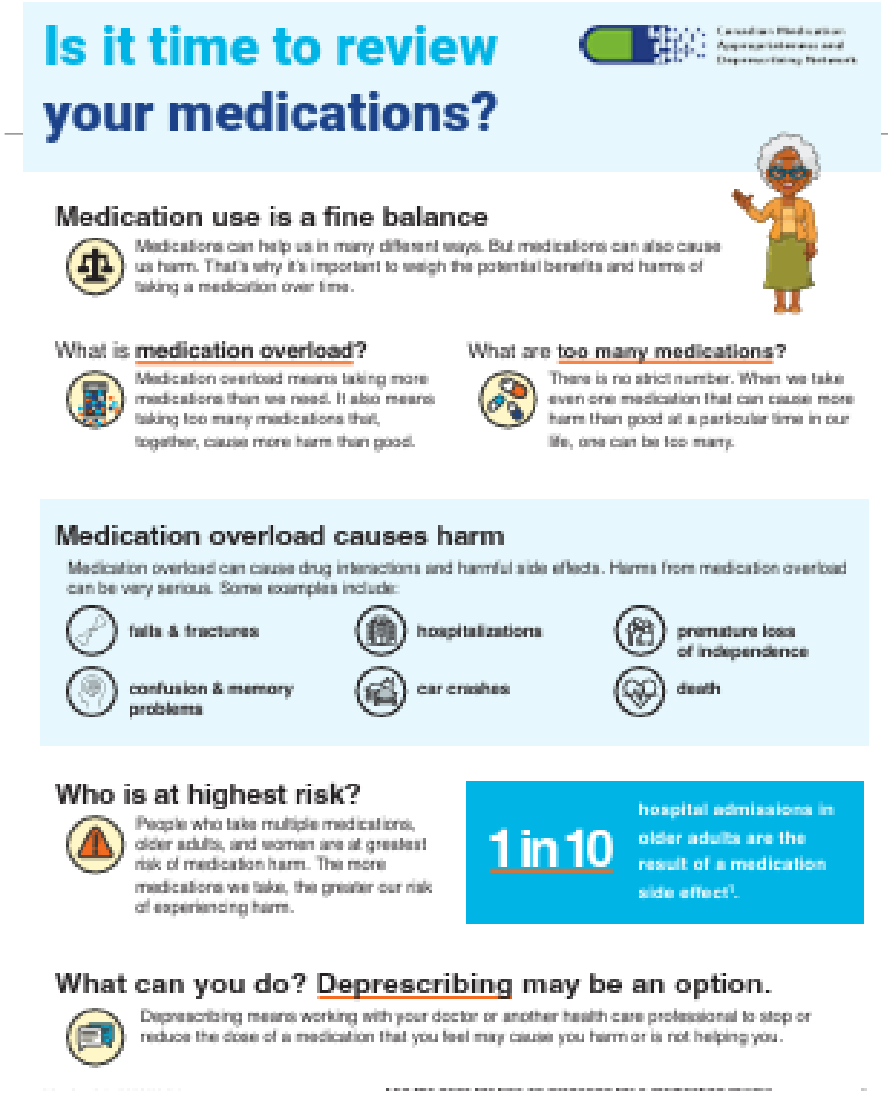
Patient Facing-Assisting Deprescribing Tool



Is it time to review your medications?

Medication use is a fine balance

Medications can help us in many different ways. But medications can also cause us harm. That's why it's important to weigh the potential benefits and harms of taking a medication over time.

What is medication overload?

Medication overload means taking more medications than we need. It also means taking too many medications that, together, cause more harm than good.

What are too many medications?

There is no strict number. When we take even one medication that can cause more harm than good at a particular time in our life, one can be too many.

Medication overload causes harm

Medication overload can cause drug interactions and harmful side effects. Harms from medication overload can be very serious. Some examples include:

- falls & fractures
- hospitalizations
- premature loss of independence
- confusion & memory problems
- car crashes
- death

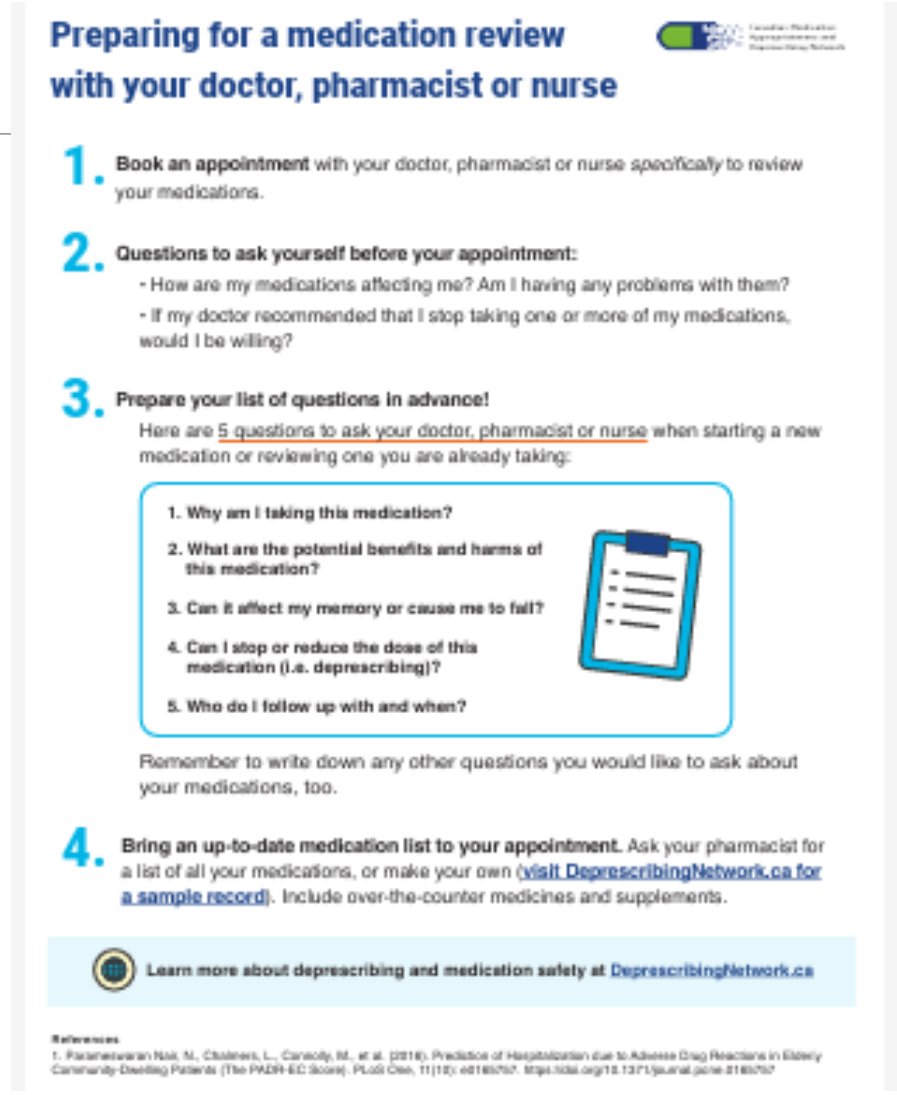
Who is at highest risk?

People who take multiple medications, older adults, and women are at greatest risk of medication harm. The more medications we take, the greater our risk of experiencing harm.

1 in 10 hospital admissions in older adults are the result of a medication side effect[1].

What can you do? Deprescribing may be an option.

Deprescribing means working with your doctor or another health care professional to stop or reduce the dose of a medication that you feel may cause you harm or is not helping you.



Preparing for a medication review with your doctor, pharmacist or nurse

1. **Book an appointment** with your doctor, pharmacist or nurse *specifically* to review your medications.

2. **Questions to ask yourself before your appointment:**
   - How are my medications affecting me? Am I having any problems with them?
   - If my doctor recommended that I stop taking one or more of my medications, would I be willing?

3. **Prepare your list of questions in advance!**
   Here are 5 questions to ask your doctor, pharmacist or nurse when starting a new medication or reviewing one you are already taking:

   1. Why am I taking this medication?
   2. What are the potential benefits and harms of this medication?
   3. Can it affect my memory or cause me to fall?
   4. Can I stop or reduce the dose of this medication (i.e. deprescribing)?
   5. Who do I follow up with and when?

   Remember to write down any other questions you would like to ask about your medications, too.

4. **Bring an up-to-date medication list to your appointment.** Ask your pharmacist for a list of all your medications, or make your own (visit DeprescribingNetwork.ca for a sample record). Include over-the-counter medicines and supplements.

Learn more about deprescribing and medication safety at DeprescribingNetwork.ca

References

1. Parameswaran Nair, N., Chalmers, L., Peterson, G. M., et al. (2016). Prediction of Hospitalization due to Adverse Drug Reactions in Elderly Community-Dwelling Patients (The PADR-EC Score). PLoS One, 11(10): e0165767. https://doi.org/10.1371/journal.pone.0165767

GLPO Polypharmacy Rates

GLPO RATE through 5/31/26:

2.13%

A lower rate indicates better performance

2026 Target to achieve 5 Stars:

≤5%

GLPO is currently 5 Stars

POLY- ACH Metric for OTHER PAYERS:

Same as BCBSM:

Priority Health

Humana

Exception of:

HAP

- Does not have a similar measure.

Concurrent Use of Opioids and Benzodiazepines (COB)

QUALITY SPOTLIGHT 2026

Did You Know the Risks of Concurrent Use of Opioids & Benzodiazepines?

Opioid prescribing at high dosage, use from **multiple prescribers and pharmacies**, and **concurrent use with benzodiazepines** is associated with an **increased risk** of chronic use, misuse, and in some cases, overdose/suicide

Additionally, **worse treatment outcomes** & **increased health services use**

The Percentage of Patients with Concurrent Use of Prescription Opioids and Benzodiazepines (COB)

Denominator:

Patients 18 and older who **meet BOTH** of the following criteria during the measurement year:

- **Two or more opioid** prescriptions filled on **different dates** of service
- Received **cumulative supply** of **opioids** for **15 days or more**

Numerator:

Patients **on opioids with BOTH** of the following criteria during the measurement year:

- **Two or more benzodiazepine prescriptions** filled with **different dates** of service
- **Concurrent** use of **opioids and benzodiazepines** for **30 cumulative days or more**

COB:
Examples of Meeting Versus Not Meeting the Measure

1. A patient that is on chronic opioids (365 days of the year) and is prescribed a benzodiazepine one time for 14 days will meet the measure.
2. A patient that is on chronic opioids (365 days of the year) and is prescribed a benzodiazepine two prescriptions. One filled for 21 days in April and other one for 14 days in July will meet the measure.
3. A patient that is on chronic opioids (365 days of the year) and is prescribed a benzodiazepine two prescriptions. One filled for 30 days in June and another for 14 days in August will fail the measure.

Helpful Hints

1. Avoid initial combination by offering alternative approaches
   - ✓ Always consider alternatives to opioids for chronic pain
   - ✓ Always consider alternatives to BZDs for anxiety or insomnia
   - ✓ Remember BZDs are not indicated to treat pain
   - ✓ Avoid prescribing BZDs for patients on MATs
   - ✓ Avoid prescribing opioids for patients taking long-term BZDs

2. If new prescriptions are needed, limit the dose and duration

3. Taper long-standing medications gradually and, whenever possible, discontinue
   - ✓ Do not abruptly stop BZDs or opioids
   - ✓ Taper slowly according to guidelines and adjust depending on symptoms
   - ✓ Always work collaboratively with your patients to taper or discontinue

4. Continue long-term co-prescribing BZDs and opioids only when necessary and monitor closely
   - ✓ Clearly explain risks and black box warnings
   - ✓ Closely monitor and consider drug testing at baseline and regularly, especially for high-risk patients
   - ✓ Set clear expectations for what steps will be taken if your patients do not follow the prescribed regimen, including safely discontinuing a medication
   - ✓ Monitor PDMP regularly

5. Provide rescue medication (for example, naloxone) to high-risk patients and their caregivers

Helpful Hints

Continued

If you determine the **benefits of co-prescribing BZDs and opioids outweigh the risks,** prescribe short-term treatments (such as, 7 or fewer days' supply and no more than 2 weeks).

You are more likely to succeed when you take an **individualized, person-centered approach**, and create treatment plans that **involve your patients' support networks, including friends, family, and caregivers.**

Opioid Medications		
Benzohydrocodone	Hydrocodone	Opium
Buprenorphine	Hydromorphone	Oxycodone
Butorphanol	Levorphanol	Oxymorphone
Codeine	Meperidine	Pentazocine
Dihydrocodeine	Methadone	Tapentadol
Fentanyl	Morphine	Tramadol
Benzodiazepine Medications		
Alprazolam	Diazepam	Oxazepam
Chlordiazepoxide	Estazolam	Quazepam
Clobazam	Flurazepam	Temazepam
Clonazepam	Lorazepam	Triazolam
Clorazepate	Midazolam	

Exclusions

Diagnosis of cancer or cancer related pain treatment

Sickle cell disease

Received hospice services anytime during measurement year

Received palliative care during the measurement year

GLPO COB Rating

GLPO Rate through 5/31/26:

5.70%

2026 Target to achieve 5 Stars:

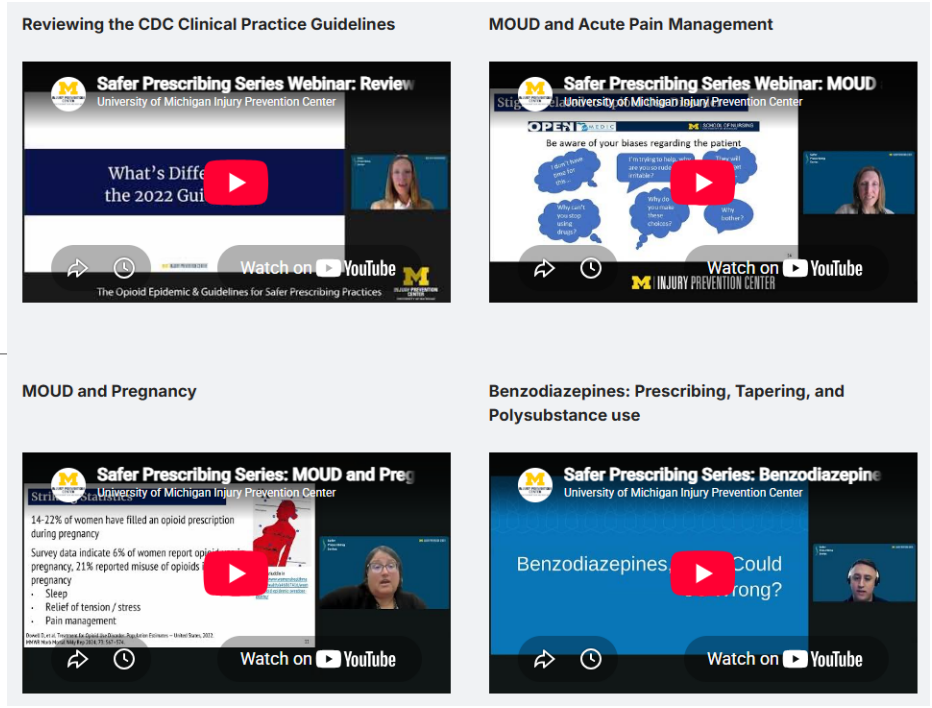
≤6%

* A lower rate indicates better performance*

GLPO is currently 5 Stars

Resources

https://injurycenter.umich.edu/sps/#past



Centers for Medicare and Medicaid Services (CMS). 2022. “CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022.” **https://cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm**

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

Centers for Medicare and Medicaid Services (CMS). 2019. “Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines.” https://www.cms.gov/sites/default/files/2022-04/SE19011.pdf

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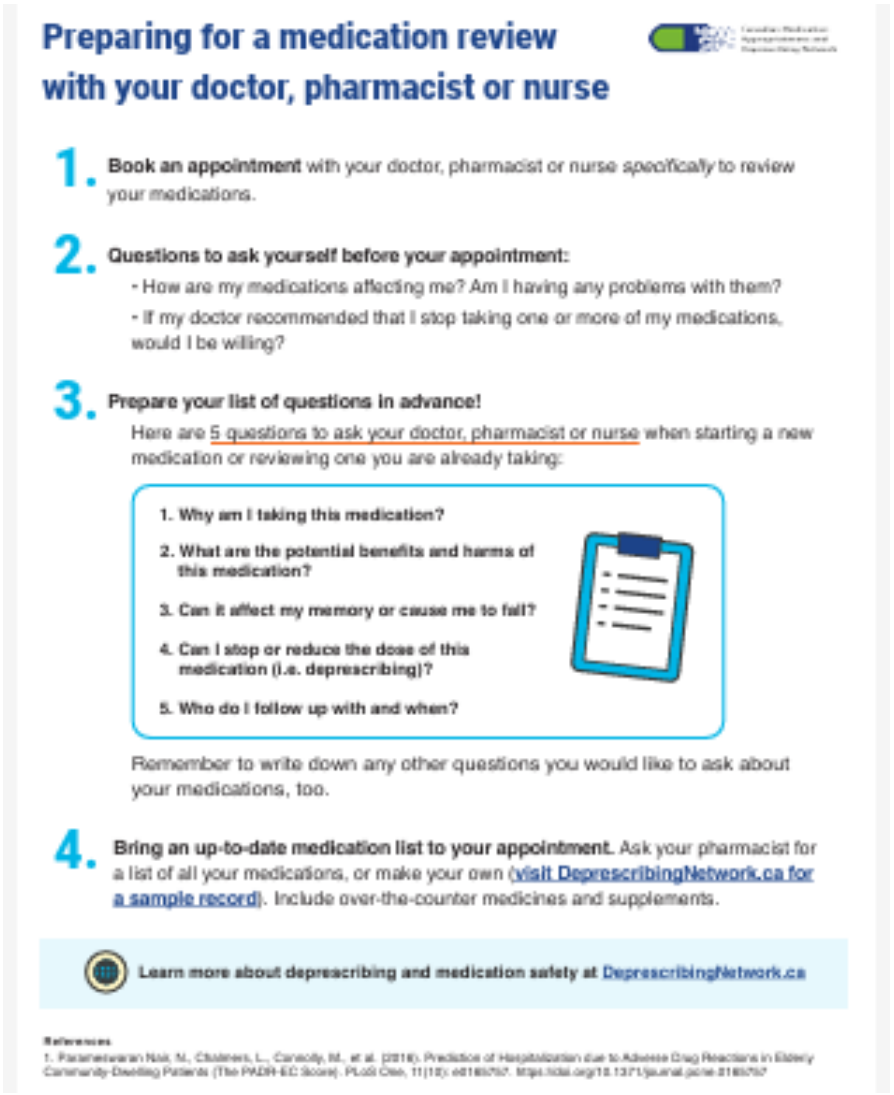

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COB for Other Payers:

Measure is the same:

Priority Health

Humana

Similar measure:

HAP

- Has a similar measure called *Deprescribing of Benzodiazepines in Older Adults*
- *Medicare Only*

Questions