

Patient Safety: At the core of evidence-based guidelines for older adults

Evidence suggests polypharmacy can create measurable health challenges, including an 88% increased risk of experiencing an adverse drug event.¹

The American Geriatrics Society recommends avoiding the concurrent use of the following in older adults:^{2,3}

- Two or more anticholinergic (ACH) medications. Multiple studies have reported an increased risk of cognitive decline with concurrent use.^{4,5,6}

Based on this evidence, the Pharmacy Quality Alliance™ (PQA) developed and endorsed the Polypharmacy: Use of Multiple ACH Medications in Older Adults (POLY-ACH) measure.⁷

Prior authorization approval may be required for coverage of medications in this measure. However, a prior authorization does not prohibit a patient from failing the measure.

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

Risks of polypharmacy use	ACH medications increase the risk of cognitive decline, delirium and falls or fractures ³
Description	Percentage of patients 65 years of age and older with concurrent use of two or more unique* ACH medications
Calculation (numerator/denominator) x 100% Lower rate is better	Numerator: Concurrent use of two or more unique* ACH medications, each with two or more fills on different dates of service Denominator: All patients 65 years or older, with two or more fills with unique dates of service for the same ACH medication
Exclusion	Hospice
Measurement period	Calendar year
General trend	Lower is better

Note: Concurrent use = overlapping days' supply for 30 or more cumulative days in measurement year

* Unique = different active ingredients

ACH medications

ACH medication class†		Possible alternatives (if clinically appropriate)^
First-generation antihistamines	• brompheniramine • chlorpheniramine • cyproheptadine • dimenhydrinate • diphenhydramine (oral)	• doxylamine • hydroxyzine • meclizine • triprolidine
		• intranasal normal saline • second-generation antihistamine (e.g., levocetirizine, cetirizine, desloratadine) • steroid nasal spray (e.g., fluticasone, flunisolide, mometasone)
Antiparkinsonian agents	• benztropine	• trihexyphenidyl
		• pramipexole immediate-release, ropinirole immediate-release
Skeletal muscle relaxants	• cyclobenzaprine	• orphenadrine
		• acetaminophen, ibuprofen, naproxen, celecoxib (consider add-on gastroprotective agent) • nonanticholinergic muscle relaxants (e.g., baclofen, tizanidine)
Antipsychotics	• chlorpromazine • clozapine	• olanzapine • perphenazine
		• low-dose nonanticholinergic antipsychotics (e.g., aripiprazole, risperidone, ziprasidone)
Antidepressants	• amitriptyline • amoxapine • clomipramine • desipramine	• doxepin (> 6 mg/day) • imipramine • nortriptyline • paroxetine
		• selective serotonin reuptake inhibitors (SSRIs),** e.g., sertraline, except paroxetine • serotonin and norepinephrine reuptake inhibitors (SNRIs),** e.g., duloxetine • bupropion, mirtazapine, trazodone • For nerve pain: gabapentin, pregabalin immediate-release or lidocaine patch
Antimuscarinics	• darifenacin • fesoterodine • flavoxate • oxybutynin	• solifenacin • tolterodine • trospium
		• Myrbetriq® (mirabegron), GEMTESA® (vibegron)
Antispasmodics	• atropine (excludes ophthalmic) • clidinium-chlordiazepoxide • dicyclomine • homatropine (excludes ophthalmic)	• hyoscyamine • scopolamine (excludes ophthalmic)
		• For constipation: lactulose oral solution • For diarrhea: loperamide
Antiemetics	• prochlorperazine	• promethazine
		• ondansetron

† Includes combination products that contain a target medication listed and the following routes of administration: buccal, nasal, oral, transdermal, rectal and sublingual. Injectable and inhalation are excluded.

^ This list may not represent medications covered on your patient's plan. Please check to ensure alternatives are available for your patient.

** SSRIs, SNRIs and tricyclic antidepressants (TCAs) are not recommended in patients with a history of falls or fractures.³

Tapering regimens for ACH medications

Drug class	Example of tapering regimen
Antidepressants	Taper 25% every 4–6 weeks ⁸
Antipsychotics	Taper 25%–50% every 1–2 weeks. If withdrawal symptoms occur, options are to slow taper further, restart at lowest dose or consider non-medication behavioral support. ⁹

Note: These tapering regimens are only provided as examples. Tapering may vary based on patient factors (e.g., duration of therapy, symptom recurrence) and the regimen should be adjusted based on patient monitoring.

Clinical best practices to reduce polypharmacy and adverse events

- Review each patient’s medication lists at every visit and specifically review patient medical records if they are taking a medication included in the POLY–ACH measure.
- Verify if POLY–ACH medications can be taken with the patient’s other medications. If there is a conflict, coordinate with the patient to ensure at least one of the concerning medications is discontinued.
- Before prescribing a new medication, review all patient-reported medications as well as those noted in any of the patient’s chart. If new medications are needed, review the POLY–ACH measure drug list prior to prescribing.
- Minimize negative outcomes when POLY–ACH medications cannot be avoided by utilizing the lowest dose and frequency.
- Ensure medications have limits to supply and/or duration when clinically appropriate.
- Document risks in the chart and discuss these with the patient. Ensure the patient has written documentation of the concern and the potential harmful effects.
- Review medications at each visit for polypharmacy and consider removal or replacement with a clinical alternative.
- Some medications in this measure may require a prior authorization approval to be covered by the patient’s plan. Please note even if the medications are deemed medically necessary and the prior authorization is approved, the patient **may still fail the POLY–ACH measure**.
- Consider non-pharmacologic options as safe and viable alternatives to anticholinergic medications when clinically appropriate.

POLY–ACH measure exclusion codes

The following billing/reimbursement codes pertaining to hospice care will be used to identify patients to be excluded from the POLY–ACH measure.

Exclusion	Pertinent codes
Hospice care	Current Procedural Terminology (CPT®): 99377, 99378 Healthcare Common Procedure Coding System (HCPCS): G0182, G9473, G9474, G9475, G9476, G9477, G9478, G9479, Q5003, Q5004, Q5005, Q5006, Q5007, Q5008, Q5010, S9126, T2042, T2043, T2044, T2045, T2046 Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT): 170935008, 170936009, 183919006, 183920000, 183921001, 305336008, 305911006, 385763009, 385765002 UB–04 Revenue Code (UBREV): 115, 125, 135, 145, 155, 235, 650, 651, 652, 655, 656, 657, 658, 659

References

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The information in this flyer reflects PQA specifications but is not meant to preclude clinical judgment. Treatment decisions should always be based on the clinical judgment of the physician or other healthcare provider.

The coding information in this document is subject to changing requirements and should not be relied on as official coding or legal advice. All coding should be considered on a case-by-case basis and supported by medical necessity and appropriate documentation in the medical record.



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