Rx Right-sizing

Experts advocate a smarter approach to polypharmacy

By Bruce Shutan

In America's pill-popping culture, it's not surprising that the prevalence of patients taking multiple medications to manage leading chronic conditions such as diabetes, heart disease, hypertension and high cholesterol is surging along with the graying of America. Just turn on any TV and commercials extolling the clinical benefits of a host of new drugs are inescapable.

The number of U.S. adults taking five or more prescription medications concurrently – a phenomenon known as polypharmacy – has more than doubled to 17.1% and tripled to nearly 44% for those age 65 in the past 20 or so years.

The implications for self-insured health plans are enormous in terms of both cost and clinical outcomes. While necessary and beneficial in many cases, this strategy also significantly increases the risk of adverse drug interactions, falls and fractures, cognitive impairment or confusion, hospitalizations, higher healthcare costs and poor adherence to treatment. That's why experts suggest a more thoughtful approach to managing polypharmacy claims.

One industry insider suggests that inappropriate prescribing of even a single script can have ramifications on par with polypharmacy concerns, noting that 30% of hospitalization issues are tied to inappropriate medications. Indeed, inappropriate administration of medications on hospital discharges can complicate matters for polypharmacy patients.

"They'll send you out with your discharge papers that are very clear about the drugs you should be on, but no one looks back at what you were on before and says, 'stop taking these,'" says Amy Ball, PharmD, President of Innovative Rx Strategies, who was a hospital pharmacy director for 10 years. "Maybe they changed medication therapy for your blood pressure or cholesterol while you were in the hospital, but nobody tells you to stop taking the medication you're on at home."

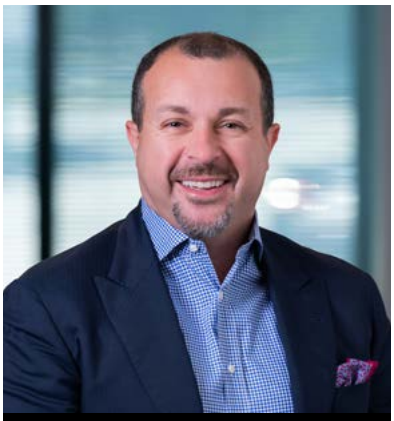

Amy Ball

The more drugs that are added to a prescription drug regimen, the harder it is to learn what's causing health problems in the first place, Ball explains. She always recommends carefully studying a patient's chart before adding scripts, which increases the chance of medication errors being made.

JUGGLING DISEASE STATES

With about two-thirds of Americans said to be overweight, the increasing prevalence of "diabesity" (diabetes and obesity) has become a major concern in polypharmacy. Many of the complications associated with diabetes result in other comorbidities that can all be diagnosed at the same time, Ball explains. When that occurs, she says "someone can go from being on zero meds to six or eight medications all at once."

Other scenarios involving multiple medications include oncology, hemophilia, Parkinson's, Alzheimer's, inflammatory bowel disease, asthma, dyslipidemia, COPD, and psychiatry conditions. They also may involve patients who start out on just one drug, having others prescribed to treat troubling side effects.


Dea Belazi

Implementing a meaningful approach to polypharmacy is particularly crucial for very treatment-resistant patients, according to Dea Belazi, Co-founder, President, and CEO of AscellaHealth. If Lipitor isn't helping lower cholesterol, for example, another statin, fibrate, or PCSK9 inhibitor may be needed.

Polypharmacy is a widely accepted medical practice to treat advanced or very complex hypercholesterolemia, diabetes or even some specialty conditions such as challenging psoriasis or rheumatoid arthritis, he notes.

"We could go through hundreds of diseases where the complex or treatment-resistant models are just polypharmacy," he says.

Another consideration is that medical advances have elevated the use of polypharmacy. Ten years ago, Belazi notes that HIV patients were burdened by a double-digit daily drug cocktail to treat their illness, which used to be a death sentence, whereas now there are combination drugs that will last multiple months and help people live with the disease.

But the model is also riddled with shortcomings. One example he cites is treating behavioral health conditions such as schizophrenia with two or three atypical antipsychotics without a single data point that suggests it's the right way to proceed. This can lead to psychiatric hospital readmissions.

When Ball did long-term care consulting at a hospital, she recalls how a physician with whom she was making the rounds one day suggested putting an elderly woman who was having heart palpitations on a beta blocker.

"In the elderly, oftentimes low thyroid can result in heart palpitations, especially in women, and so I noticed in the chart that no one ever done a thyroid test on her," she says.

It turns out that her hunch was right after running a test: the patient didn't need to go on a beta blocker after all. The danger in prescribing it for the elderly is that they're more prone to falling and breaking their hip when getting out of bed, standing up and walking. As people age, she notes that muscle mass decreases, they lose weight and become more fragile, which means they may not need the same level of drugs that they did when they were younger. In addition to losing their mobility, they could also develop an infection and increase their risk of mortality.


Adva Tzuk

Most patients who are older than 65 have more than 10 medications to manage their chronic disease states, thus making them more prone to acquiring polypharmacy status, notes Adva Tzuk Onn, M.D., a family and geriatric physician and Chief Medical Officer at FeelBetter. With an aging population working later into life, this becomes a concern for employers that are trying to retain graying talent with deep knowledge and institutional memory.

THE IMPACT OF GLP-1S

With so much attention drawn to the use of GLP-1 drugs for weight loss, this trend could have a massive impact on polypharmacy. As more people on those drugs are able to lose weight, Ball says lower blood pressure, cholesterol, and blood-sugar levels could help eliminate the need for meds to treat those conditions. By the same token, she notes that there's still uncertainty around how other drugs interact with GLP-1s.

"We could potentially have up to 40% of the U.S. population on GLP-1s based on obesity statistics," Ball predicts. "That's a big deal."

Most people with Type 2 diabetes are on two or three medications that could be include a generic drug called Metformin or branded set of drugs called SGLT2, which helps rid urine of sugar, Belazi explains. In addition, they could be on a GLP-1 to lose weight. He says what's worth noting is that weight-loss drugs have many side effects and that a significant proportion of those who've been prescribed the medication gain back most or all of their weight if they stop using it.

While the addition-by-subtraction approach to polypharmacy will no doubt help weed out unnecessary or harmful scripts in a patient's drug regimen, it's vital not to lose sight of a larger goal. Tzuk Onn suggests using medications as a tool for whole-person health vs. focusing too narrowly on medication adherence and deprescribing.

At the heart of polypharmacy is a need to first examine whether there are any indications that prescribed medication is inappropriate for a patient, according to Tzuk Onn. In some cases, the script may no longer be needed after being taken for a while and showing tepid or poor results.

Another concern she has is whether an appropriate dosage has been dispensed for each particular condition (i.e., the amount of medication for hypertension or cardiac arrhythmia might be different). Issues involving kidney and hepatic functioning, as well as the patient's age, will require a change in dosage according to the patient's comorbidity and elements of the drug's pharmacokinetics.

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AI'S HELPING HANDS

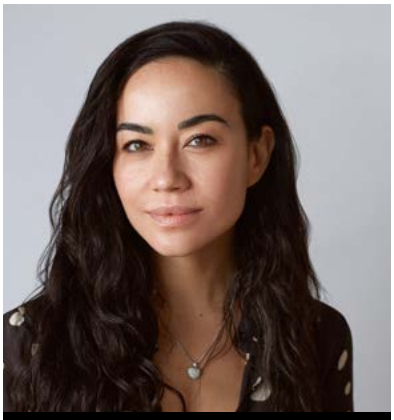
Since it's easy for time-pressed physicians to encounter drug-interaction alert fatigue, Tzuk Onn says it's important to prioritize a review of potentially dangerous interactions, "and then you have to see what happened once you gave both medications," she adds. This is where technology can help because unlike physicians, chatbots can follow patients who have multiple diseases all of the time and assess the dangers of so-called drug-drug interactions.

Considering that clinical pharmacists may be responsible for anywhere from 500 to 100,000 patients, she considers technology vital to helping them manage a heavy workload and approach patients who need them the most. Artificial intelligence can provide a list of patients and the necessary insight so that each clinician has a comprehensive view of each patient and understand the relationship between their conditions, medications, lab tests, and overall wellbeing. "Instead of seeing just one patient, they would be able to see up to 10 patients at the same time," she says.

The trouble with these AI agents is that they save any information given to them, which would violate patient privacy, "and we don't know what they will do with that," she cautions. Given that they're also not actually clinical pharmacists and have limitations, she says users cannot trust the information they dispense.

However, Tzuk Onn believes the technology can be quite useful if an AI algorithm is trained on evidence-based and rule-based data that is kept anonymous to ensure the information isn't used for nefarious purposes and quality assurance is implemented to verify results.

REPLACING PILLS WITH CANNABIS



Emily Fisher

Making available Rx alternatives can help make a dent in polypharmacy claims. Research shows that cannabis helps patients achieve better symptom management, reduces their reliance on prescription medication, and on occasion, completely eliminates them altogether, explains Emily Fisher, Founder and CEO of Leafwell, whose team of data scientists, cannabis specialists, and patient advocates help people unlock the medicinal benefits of cannabis.

As a two-time breast cancer survivor, Fisher knows that while polypharmacy is a necessary tool for clinicians to manage disease, taking several powerful medications at the same time also can produce harmful side effects. Having worked with thousands upon thousands of patients, she says cannabis is a much safer and gentler alternative to pharmaceuticals for chronic conditions.

Leafwell, which facilitates more than 20,000 monthly clinical encounters across the U.S. for patients exploring cannabis therapy, has been collecting millions of data points. One such finding was a more than 50% drop over a three-month period in the use of multiple medications, including opioids, taken to treat anxiety and sleep disorders in over 250,000 patients who were surveyed between 2021 and 2024.

Fisher says there are some very practical steps employers can take to reduce adverse drug interactions and eliminate unnecessary scripts. One is to embrace a fiduciary-aligned pharmacy benefit manager that ensures contracts mandate 100% pass through of manufacturer rebates and replace percentage-of-cost fees with a fixed administrative charge.

"Organizations whose incentives are aligned with employers formalize a managed deep prescribing protocol to integrate automated data tools that flag candidates for treatment de-escalation," he explains.

From the perspective of cannabis therapy, she says it's important to introduce evidence-based adjunct therapies early. When clinically guided and structured correctly, they lower the risk of this cascading prescribing effect that can happen with polypharmacy, reduce the reliance on prescription medication, support better symptom management and improve quality of life.

The ultimate goal behind any attempt to clean up polypharmacy is to elevate clinical value and outcomes. "If I was a self-insured employer, health plan, TPA or whatever," Belazi says, "I would be very much focused in this particular area with their partners or vendors, whether it's a PBM or otherwise, to be looking at what programs are in place – particularly around spending money on drugs that don't have an effect."■

Bruce Shutan is a Portland, Oregon-based freelance writer who has closely covered the employee benefits industry for nearly 40 years.