Polypharmacy: From Common to Commonsense

It is not uncommon for adults with intellectual and development disabilities (I/DD) to have multiple comorbidities and to be on a number of medications. As a result, they are at risk for polypharmacy, which can lead to a prescribing cascade, where a new drug is prescribed to address a side effect or adverse reaction of another.

When the pharmacist, prescriber, and other team members work together to address polypharmacy in this population, it not only can prevent the prescribing cascade and keep people out of the hospital, but it also can help improve quality of life and enable them to be as functional and independent as possible.

While the prescriber and pharmacist play key roles in addressing polypharmacy, a whole-team approach to the issue is key. Here are four steps that can help:

1. **Promote a consistent understanding of polypharmacy.** There are various definitions of polypharmacy. It is important for your team to be on the same page and use common language. William Mills, MD, senior vice president of medical affairs for BrightSpring Health Services, said, "A study analyzing the various definitions of polypharmacy in the medical literature found that the most commonly reported definition was a patient who is taking five or more medications daily (46.% of articles), with definitions ranging from two or more to 11 or more medicines.[1] Other studies have shown that the risk of adverse drug effects increases as the number of daily medications rises."

   He added that people with I/DD are living longer, so they are experiencing the conditions of aging that often mean more medications. It is important for the care team to realize that older individuals with I/DD share many of the same healthcare challenges and issues as others their age without I/DD. This means understanding that medications such as benzodiazepines, hypnotics, sedatives, antihistamines, and some blood pressure and heart medications can be contraindicated or cause adverse events. "If we can identify and remove drugs that increase the risk of adverse events such as falls, we can keep people safer and more independent," said Mills.

2. **Work together to identify non-drug interventions.** "There are a great deal of data showing that non-medication interventions can be the most helpful for behavioral management," said Mills. Perhaps most helpful, he suggested, is redirection, which enables you to shift a person's attention from what is causing them anxiety, fear, or anger to a more pleasant situation or feeling. Increasing socialization and exercise also are useful for preventing behavioral issues. You don't have to reinvent the wheel on this. There are useful resources out there, such as this one from Rutgers University.

   With this approach, it is important to gain insights from those who know the person best – such as family members or close caregivers – about why they may be acting out and how to manage it. Of course, Mills noted, there will be

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situations when medications are appropriate. In these instances, he said, "It is key to have pharmacist-led involvement to look at the person's medication regimen and communicate with the prescriber about possible therapeutic substitutions, dose reductions, or opportunities to eliminate drugs that are no longer appropriate or necessary."

3. **Prioritize ongoing, inclusive care planning.** Care planning isn't one and done, and it needs to involve full representation from the care team, including but not limited to, the pharmacist. "It's useful to a maintain a full list of patients with behavioral issues and optimize the pharmacists' and others' time to plug into these, "Have an open dialogue and give everyone a chance to offer their insights and ideas," said Mills.

4. **Engaging families.** Families may see more medications as better or not understand why their loved one is taking certain drugs. "We need to help them understand the disease process and diagnoses in lay terms and explain how illnesses may progress," said Mills. For instance, if they understand that mom's dementia may cause sundowning late in the day, they can schedule visits earlier in the day, instead of expecting another drug to solve the problem.

   At the same time, Mills suggests, "Help them understand redirection techniques, for example, letting them know that arguing with someone who has cognitive impairments isn't helpful. Instead, giving gentle reassurance and redirecting them back to the topic is more likely to have a positive impact."

When everyone is on the same page and works in sync to care for people with I/DD and ensure the best possible outcomes, they can help manage polypharmacy when it occurs – and prevent it whenever possible. This takes coordination, communication, and collaboration that not only benefits people with I/DD but enables more engaged, connected teams.

1. Masnoon N, Shakib S, Kalisch-Ellett L, Caughey GE. What is polypharmacy? A systematic review of definitions. BMC Geriatr. 2017 Oct 10;17(1):230. doi: 10.1186/s12877-017-0621-2. PMID: 29017448; PMCID: PMC5635569.