As a follow-up to the June issue, themed on anticoagulants, Assistant Editor Kaylee Mehlman interviewed Casondra Seibert, PharmD, BCGP, for an industry perspective on this topic.

Postsurgical Thromboprophylaxis—The Need for Evidence-Based, Unified Regimens

Senior care pharmacist serving patients postsurgical discharge might observe any number of postsurgical thromboprophylaxis regimens. Readers might be laughing and shaking their heads at this, contemplating the various anticoagulation combinations seen daily. Complicating things further, many of the readily accessible resources lack consensus. As an example, Anderson and colleagues indicated appropriateness of aspirin 81 mg once-daily therapy postoperatively for venous thromboembolism prophylaxis after total knee arthroplasty or total hip arthroplasty surgery for 14 and 35 days, respectively.[1] Yet, the American Society of Hematology recommends clinicians use aspirin 81 mg twice daily for these same conditions.[2] But, where do heparin, low-molecular weight heparins, and direct oral anticoagulants then fit into this clinical picture? Observing examples of prescribing inconsistency, The American Society of Consultant Pharmacists (ASCP) Quality Improvement Project (QIP) Committee is conducting a literature review to evaluate regimens backed by evidence-based medicine in hopes of bringing unity to this "anything goes" arena.

As mandated by the Affordable Care Act in 2011, Health and Human Services was charged with implementing the National Strategy for Quality Improvement in Health Care.[3] Post-implementation, the Office of the Inspector General noted a staggering 22% of Medicare beneficiaries in the postacute setting experienced an adverse event during their stay.[4] Of that patient population, 35% of the adverse events were attributed to medication use, and excessive bleeding secondary to medication use was identified as a safety concern. This likely comes as no surprise. Fast-forward to current practice, it is no wonder these events are occurring as confusion among which agent to use, doses, duration of therapy, and when the patient should return to chronic prophylactic therapy guidance is varied. Adding in the additional complications of transitions-of-care, proper medication reconciliation, patient comorbidities, and a growing list of anticoagulant medications—clinicians need a life raft for anticoagulant prescribing.

Senior care pharmacists have the potential to assist in demystifying postacute anticoagulation management and improving patient safety outcomes. Even with variable guidance currently available, pharmacists can still make a difference. During a recent call, ASCP QIP Chair Jaron Stout stated, "Anticoagulants should never be taken at face value. Always dig to find a diagnosis and ensure anticoagulant appropriateness." Focusing on the *why?* of anticoagulant prescribing is a solid first step, and it may even result in patient-centric change and adverse event reduction.

If you or a colleague are interested in participating in the above-mentioned literature review, please email info@ascp.com with "QIP Anticoagulation Systematic Literature Review" in the subject line.

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