



Encouraging Next Steps in Venous Disease Care



Indiana University Health

Friday, April 29
2016

Table of Contents

Course Description.....1

Course Objectives.....2

Accreditation Statement, Designation Statement,
Faculty Disclosure Statement, Note, Location.....3

Agenda4 – 6

Chair/Champions, Contact Information7

Registration Form8

Encouraging Next Steps in Venous Disease Care

Course Description

According to the Centers for Disease Control and Prevention (CDC), each year an estimated 300,000 – 600,000 (1 to 2 per 1,000) Americans are impacted by morbidity and mortality associated with acute venous thromboembolism (VTE)—defined as deep vein thrombosis (DVT), pulmonary embolism (PE), or both. Diagnosis may be difficult to make in patients affected with other medical issues stressing the need for accurate diagnostic algorithms.

Each year, 60,000 – 100,000 Americans die due to PE, this occurs within one month in 10 – 30 percent of individuals and up to 30 percent will experience a recurrence within 10 years. PE is the number one cause of preventable death in hospitalized patients suggesting that imparting knowledge of methods to prevent it is of value to our patients. In addition, approximately 50 percent of individuals who have experienced a DVT will suffer long-term complications (the post-thrombotic syndrome) when treated by current anticoagulation regimens. In addition to the post-thrombotic syndrome, primary syndromes affecting the lower extremity venous system can mimic the findings of the post-thrombotic syndrome, which are leg swelling, skin changes and difficult to heal ulcers. These two etiologies taken together define Chronic Venous Disease (CVD) and when the entire spectrum is considered, 30 million Americans are affected by CVD. Varicose veins are observed in about 25 percent of adults, 6 percent advance to significant edema and skin changes, and 2 percent will have a venous ulcer. Sequelae of this disease can be treated and early treatment prevents progression to more advanced stages such as damaged skin and even ulceration.

The annual cost to treat venous ulcers is estimated to be \$1 – 2.5 billion. In fact, the overall economic impact of VTE and its associated complications is difficult to define due to its complex nature and life-long impact—approximately two-thirds of the cases occur among outpatients. Data analysis of recent healthcare claims indicates that each year, \$2 – 10 billion can be attributable to VTE—ranging from \$7,594 – \$16,644 per patient. These statistics demonstrate that there exists an opportunity for better care leading to better patient outcomes in all aspects of venous disease patient care.

During the past 10 years, various federal and national public health agencies have launched initiatives to acknowledge VTE as a growing problem, to recognize that it is the most preventable cause of hospital death, and to increase awareness and promote appropriate prophylaxis among high-risk patients. Unfortunately, the ability to stimulate the same response for the care of patients with CVD has been lacking, most likely due to its chronic nature and often not life-threatening nature. We can do better than we are doing now. There is a need to increase awareness regarding the alternatives to current regimens of care. Further, it is critical to target the providers who are at the frontlines of care, such as the emergency medicine physicians, primary care physicians, wound care specialists and advanced care providers, as reflected by the champions of this symposium and related fields. These complex issues will be discussed in this symposium with the presentation of evidence-based guidelines and exposure to the latest approach in treatment and care.

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Course Objectives

At the conclusion of this program and based on societal practice guidelines, participants should be able to:

- Utilize a Caprini risk stratification to determine appropriate intensity of venous prophylaxis for hospitalized surgical patients and understand risk stratification and options for venous prophylaxis of hospitalized medical patients.
- Recognize that for a clearly provoked first venous thromboembolic event (example: recent major orthopedic surgery), patients should receive anticoagulation for three months. For all other venous thromboembolic events, a thoughtful shared decision should be made with the patient to consider either continued full dose anticoagulation or low dose aspirin therapy.
- Use clinical measures to discern those patients with pulmonary embolism who can be safely treated outpatient with systemic anticoagulation and those who require inpatient treatment. Patients with pulmonary embolism and findings of shock or right ventricular strain with large clot burden need consideration of thrombolytic therapy.
- Recognize that active, healthy patients with iliofemoral and subclavian/axillary DVT are subject to increased long-term morbidity when treated with anticoagulation alone and should instead be considered for clot removal therapy.
- Treat the signs and symptoms of chronic venous disease early to prevent progression and eliminate saphenous reflux to prevent recurrent ulceration in patients with superficial venous disease, and if iliofemoral venous occlusive disease is present in a patient with recurrent venous ulceration suggest iliofemoral venous stent placement.

Accreditation Statement



The Indiana University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Designation Statement

The Indiana University School of Medicine designates this live activity for a maximum of 7.25 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Faculty Disclosure Statement

In accordance with the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support, educational programs sponsored by the Indiana University School of Medicine (IUSM) must demonstrate balance, independence, objectivity and scientific rigor. All faculty, authors, editors and planning committee members participating in an IUSM-sponsored activity are required to disclose **any relevant financial interest or other relationship with the manufacturer(s)** of any commercial product(s) and/or provider(s) of commercial services that are discussed in an educational activity,

Note

While it offers CME credits, this activity is not intended to provide extensive training or certification in the field.

Pharmacy Statement



This activity has been approved for 7.25 ACTIVITY BASED CE credit hours for pharmacists by Indiana University Health. Pharmacists should claim only the credit commensurate with the extent of his/her participation in the activity. IU Health is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

UAN# 0855-9999-16-040-L01-P

Speaker and Program evaluations will be distributed to you through your email address following the conference. Please look in your email inbox for an invitation to complete the evaluation.

Participants must complete the Speaker and Program Evaluation in order to receive an ACPE Statement of Credit. The evaluation must be completed within 14 days after the program date. ACPE Statements of Credit may then be printed off of the NABP website, after the program has been processed by IU Health, ACPE and NABP. Please allow 4 – 6 weeks for processing.

Nursing Statement

IU Health Indianapolis (OH-412, 6/1/2016) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center's Commission on Accreditations.

Participants will receive 7.16 contact hours (2.0 Pharmacology contact hours) for attendance and submission of an evaluation.

Location

The Symposium will be held at Hine Hall, University Conference Center, 875 W. North St., Indianapolis, Indiana. Parking is available directly under the Hine Hall side of the facility at the corner of North and Blake Street.

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AGENDA

7 – 8 am	SIGN IN/BREAKFAST/MINGLE
8 – 8:05 am	Michael C. Dalsing, MD – Vascular Surgery Welcome Introduction/Purpose and Goals of this Educational Symposium
8:05 – 8:15 am	Jonathan Gottlieb, MD – Administrative Perspective External Expectations, Risks, Opportunities Connecting optimal care with the ability to continue to provide care
8:15 – 8:25 am	Michael Kraus, MD – Nephrology Service Why are practice guidelines important? Does a standard approach to care improve patient outcome?
8:25 – 8:50 am	Mark Luetkemeyer, MD – Hospitalist Service DVT Prophylaxis in the Hospitalized Patient
8:50 – 9:15 am	Alexander J. Ansara, PharmD, BCPS-AQ Novel Oral Anticoagulants: What they are and how to use them
9:15 – 9:40 am	Rakesh Mehta, MD – Hematology Service My Patient has a DVT: Now what?
9:40 – 10:05 am	Sherrine A. Ibrahim, MD – Obstetrics & Gynecology, Maternal & Fetal Specialist VTE during Pregnancy: Diagnosis and Treatment
10:05 – 10:20 am	BREAK/REFRESHMENTS
10:20 – 10:45 am	Daniel W. Belcher, MD – Internal Medicine/ Primary Care New Anticoagulants and the Elderly Population: To switch or not
10:45 – 11:10 am	Jeffrey A. Kline, MD – Emergency Medicine Service Acute Pulmonary Embolus: Treat at home, who and how?

11:10 – 11:35 am	Breakout Session Questions to be considered and each group will pick a leader to present their conclusions to the entire group: How do you use guidelines in your practice? How do you manage DVT prophylaxis in your hospital—is it hardwired in any way? Who manages the post-hospital DVT prophylaxis or is it even a concern? What do you see your role or what do you do in the care of acute DVT, cessation of treatment, and follow-up thereafter? How do you currently manage pulmonary emboli and can you see a change in that management based on this session?
11:35 am – noon	Present findings of breakout session to the larger group Questions and discussion with panel
Noon – 1 pm	LUNCH
1 – 1:25 pm	Scott D. Roberts, MD – Intensivist Service Acute Pulmonary Embolus Management: Past Basics
1:25 – 1:50 pm	Douglas K. Nam, MD – Cardiology Service Pulmonary Hypertension: Beyond shortness of breath
1:50 – 2:15 pm	Thomas Casciani, MD – Interventional Radiology Acute DVT: When clot removal is warranted
2:15 – 2:40 pm	Michael C. Dalsing, MD – Vascular Surgery Chronic DVT: Early recognition, treatment and time to refer
2:40 – 2:55 pm	BREAK/REFRESHMENTS

AGENDA *continued*

2:55 – 3:20 pm	David A. Johnson, MSN, FNP-BC – Nurse Practitioner Transition of Care and Communication
3:20 – 3:45 pm	Ben L. Zarzaur, MD – Outcomes Consultant The Data: How is Indiana doing in the care of patients with VTE?
3:45 – 4:10 pm	Breakout Session Questions to be considered and each group will pick a leader to present their conclusions to the entire group: What patients do you treat aggressively for acute DVT or is everyone best managed by anticoagulation alone? What do you tell your patients regarding this care? Do you have the expertise to manage the complex PE (acute or chronic) patient in your facility? Would regional help be useful and for which patients? When do you consider chronic venous insufficiency in your patients with severe edema or skin changes/ulcers, what do you do to evaluate and when does referral become a consideration? The increasing utilization of a hospitalist model of acute care is a blessing in some respects, but a challenge in others. How are you handling transitions of care, and is it working?
4:10 – 4:35 pm	Present findings of breakout session to larger group: Questions and discussion with panel
4:35 – 4:45 pm	Michael C. Dalsing, MD – Vascular Surgery Closing comments and thank you
4:45 – 6 pm	Wine and cheese, meet the faculty and other attendees

Chair

Michael C. Dalsing, MD
Vascular Surgery

Champions

Alexander J. Ansara, PharmD
Pharmacy

Daniel W. Belcher, MD
Internal Medicine/Primary Care

Thomas Casciani, MD
Interventional Radiology

Jonathan E. Gottlieb, MD
Administration

Sherrine A. Ibrahim, MD
OB/GYN, Maternal & Fetal Specialist

David A. Johnson, NP
Nurse Practitioner

Jeffrey A. Kline, MD
Emergency Medicine

Michael A. Kraus, MD
Nephrology

Mark A. Luetkemeyer, MD
Hospitalist

Rakesh P. Mehta, MD
Hematology

Douglas K. Nam, MD
Cardiology

Scott D. Roberts, MD
Intensivist

Ben L. Zarzaur, MD
Outcomes Consultant

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We want everyone to feel welcome at this and other CME events. If you have a disability and need an accommodation to participate in this program, we will try to provide it. Please contact the CME office before you come to the event. At least 72 hours notice may be necessary.

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**Friday, April 29
2016**

Register online at: <http://goo.gl/JxXNz0>

After April 26, 2016, please register at the door.

There is no registration fee for this program; however, preregistration is appreciated.





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