Right Care, Right Now™—You can make a difference

It is a distinct privilege to serve as president of the Society of Critical Care Medicine (SCCM). Ascending to this position has been a humbling honor and certainly a career highlight. When I first assumed this office, I promised to make the commitments necessary for this to be an exciting and dynamic time for SCCM. During this year as SCCM president, I recognized that along with the entire SCCM membership and staff, we could make a distinct difference for SCCM—and I believe that we have.

Looking back on the Society's recent accomplishments, it is clear to me that we have also made significant strides in improving critical care medicine. For this, I owe a significant debt of gratitude to the SCCM volunteers and staff and to members of the council and executive committee for allowing me the opportunity to serve with this organization's leadership. I also must thank you directly as individuals for your participation as SCCM members, as it is you who have provided SCCM with many of the ideas and inspirations that have made change possible. I am exceedingly proud of the way the SCCM membership continues to rally around the Society's mission, its initiatives, and its goals as we all strive to improve care for the critically ill and injured.

As you would expect, there are many individuals that I have learned from over the years and many that have provided encouragement, superb mentorship, and honest guidance that have helped me tremendously with my choices. Most of you know who you are, but some of you do not. I want all of you to know that you have my deepest heartfelt appreciation. Additionally, to my wife and two daughters, my words cannot express the love and gratitude that I have for each of you. You have provided so much in the way of support, understanding, and encouragement through the years. Thank you, you are precious, and may each of you have your own sweet successes.

A Balance and a Vortex

Providing high-quality clinical care while simultaneously maintaining the focused energy necessary for successful education strategies and productive research programs across the healthcare continuum remains a significantly difficult core set of issues worldwide. Unfortunately, access to the various resources for optimal care, education, and research are subject to intense pressures, such as changing business and economic models in health care, a continued shrinking of the human resource pool of trainees, and the ongoing maldistribution of experienced providers who are often administering care in aging physical plants. Serious consideration is needed for reassessing basic healthcare education strategies so that truly safe team-oriented patient care becomes predominant in the entire variety of institutions and practice environments. For this to occur, the persistent "silo-effect" of healthcare education will need to be transitioned to new models of integrated, multiprofessional educational strategies that reach across multiple departments, schools, and institutions, while also utilizing advance technology and leading-edge education principles. Research funding on an international level has improved in recent years, but further redevelopment, solicitation, and channeling of funds from traditional and novel sources still are required for continued successes for the next generations of healthcare research. Despite these challenges, this also means that there are numerous opportunities for growth and expansion for each and every one of us.

There are a multitude of competing influences on health care and an escalating vortex of pressure for change in health care that continue to grow, seemingly without boundaries. This trend is not likely to stop in the near future until public pressures continue to build and precipitate further policy change. This is unlike any other industry or sector of the American and global economy. While many countries have different economic and business models for health care, the United States system is wealthy but perceived by many as an out of control system. Fortunately, or unfortunately, those with this perception are now also in the leadership positions of influential organizations and are not limited to each one of us struggling to get through a shift or a day in the intensive care unit (ICU). The difficulty now is not so much building awareness for problems in critical care as it is building the processes to initiate and manage change—a change that can effectively permeate throughout health care to result in safe, reliable, and efficient care. It is a reactive industry in the United States, and it lacks a uniformed proactive approach for consistent high-quality health care. The Society, however, has taken several proactive approaches in the recent past to facilitate the types of positive change required in health care.

The United States Centers for Medicare and Medicaid 2004 Annual Report was released in 2005 using the most recent 2003 data. The Centers for Medicare and Medicaid note that total healthcare costs are now $1.7 trillion, and for the first time, this is more than 15% of the gross domestic product (GDP). Almost one third of these costs ($516 billion) are related to hospital care. We often state that 25% to 40% of hospital costs are related to critical care. So, if an approximation for ICU costs at 33% is utilized, then this equates to $172 billion—still about 10% of the total healthcare costs in America or 1.5% of the gross domestic product.

Using this American example, then obviously, critical care medicine continues to represent a significantly large healthcare resource that participates in exceedingly high-stakes outcomes, but unfortunately, it is still managed with relatively high levels of inefficiency and incongruities. Fortunately, critical care is finally becoming a target within many healthcare systems and healthcare organizations. It gradually is undergoing system-

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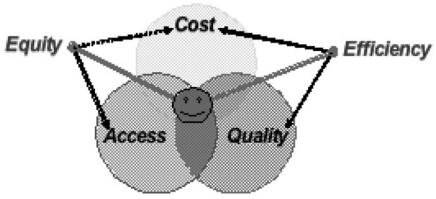

Figure 1. Balancing healthcare economics.

based revisions due, in part, to the now-recognized life and death situations occurring hourly in ICUs around the world. The high cost of ICU care is gaining recognition, especially since these costs are incurred in an increasingly competitive marketplace where errors affect not only lives, but also the bottom line. Seeking successful ways to balance health care (Fig. 1) in terms of cost, access, and quality as well as dealing with the vortex of pressures on health care (Fig. 2) and managing the multitude of factors within critical care is complicated, confusing, and very expensive. This is at least one reason for the Right Care, Right Now™ campaign from SCCM.

The Environment and the Society of Critical Care Medicine

The Society has been working successfully for a long time. It sustained rapid membership growth and notoriety within health care during its first 30 yrs, from 1970 to 2000. For the past few years, SCCM has undergone an incredible period of stabilization and consolidation of its infrastructure following relocation to the Chicago offices. The results since 2001 show that the Society, in membership, number of programs offered, and gross revenues, is growing more quickly than ever. The Society is well established as an international organization, with approximately 13,000 members, and the ongoing development of SCCM remains impressive, as this vibrant, growing organization continues to expand its influence on national and international health care. The scope of activity for SCCM, through the integrity of its programs and the commitment to excellence for its products, has continued to broaden, and opportunities to collaborate with other organizations continue to expand. The organization progressively has developed a sophisticated strategic planning program, and the SCCM Council has become refined in its focus as an oversight board of directors. Last year during my presidential address at the 34th Critical Care Congress, I outlined the challenges presented to us in the critical care environment, addressed the need for change in health care, and discussed how we could work together to make that change a reality.

The Society has many examples of successful activities it undertook during 2005:

1. A review and reorganization of the SCCM committee infrastructure occurred to facilitate future organizational growth and an ongoing alignment of related activities.
2. Consolidating trust and strength of purpose within the organization's leadership, staff, and volunteers was prioritized by improving the flow of information and increasing efforts toward effective communication and a review of governance structures.
3. The processes and reporting efforts for an organizational system of "horizon scanning" were updated to maintain optimal flexibility and nimbleness by SCCM for the rapidly changing external world.
4. Goals were reset for the future scope of involvement and the potential scope of influence of SCCM as an organization within the hierarchy of national and international organized health care.
5. An assertive expansion of the collaborative, strategic partnerships with other professional societies and organizations on a national and international basis was initiated, while the Society reassessed the focus and future direction of SCCM industry-related partnerships.
6. The need for continual review and improvement of the leadership development strategies for SCCM was reaffirmed, as well as the need to continually refine the methods for coordinating a successful future development for SCCM as an organization.
7. A growing recognition that there is a need to improve the systems of organization and the processes for providing care by intensivists to critically ill or injured patients outside the traditional geographic locations of ICUs.
8. There was an ongoing involvement of SCCM leadership with the development of standardized measurements for evaluative outcomes of ICU care and the involvement of SCCM with the evolving patient safety initiatives within health care.
9. There was further development and recognition that SCCM represents an essential component of the national and international disaster preparedness initiatives in health care. The associated SCCM education programs in this area are regarded highly.
10. There was a recognition that there needs to be an improved venue for maintaining the knowledge, experience, and contributions for all past SCCM leaders.

Many of these successes are related to the outstanding commitments from you, the SCCM volunteers and membership, but we also must recognize that the entire staff at SCCM has continued to work wonders in terms of providing high-caliber management and program development initiatives from which the organization clearly has benefited. This includes the successful strategy of advance preparation through scenario planning, and the unexpected need to relocate the 2006 Annual Congress from New Orleans, LA, to San Francisco, CA. As the magnanimity of the 2005 New Orleans disaster was appreciated, SCCM had its entire Congress relocated essentially intact within about one week of decision point—a truly successful effort given that we are already planned out 10 yrs in advance for other future Congress meetings.

We have come a long way over the past year, but as I leave this position, I realize there is much left to do. The time to initiate further large-scale change is superb because the profile of critical care within health care is more prominent than ever before. We are making a difference as an organization, and the SCCM leadership is clearly intent on leveraging this current healthcare climate for the maximal potential benefit of patients, families, institutions, and providers. I encourage each of you to continue to make your own difference in the critical care community and to draw from our successes over these past few years.

The Society launched the Right Care, Right Now™ campaign to highlight how important it is for each of us to make a commitment to providing optimal care at

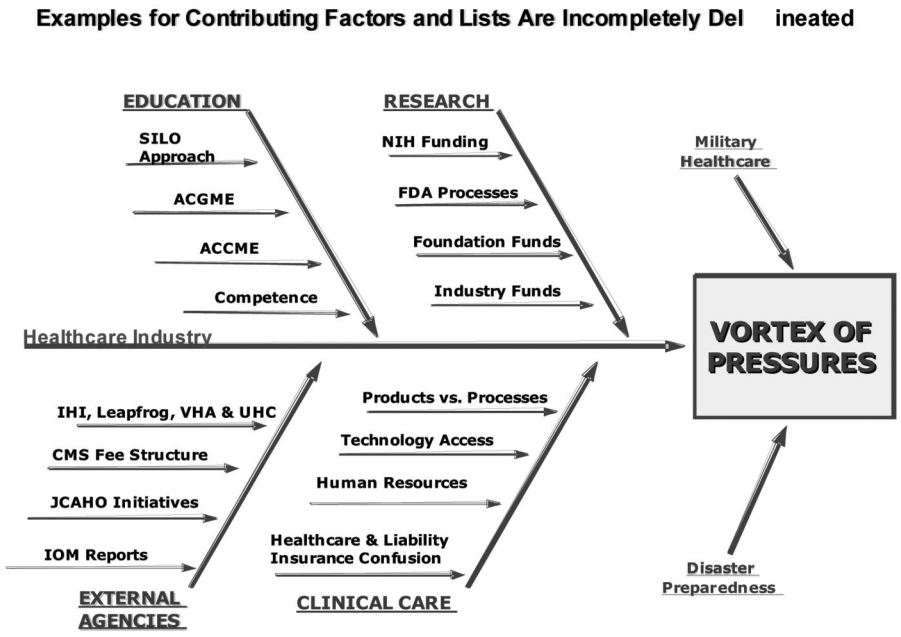

Figure 2. Vortex of healthcare pressures.

all times. Patients and families ultimately will benefit from these personal commitments, and we must keep them continually in the forefront of our minds. Take the time to refocus your perspectives on critical care, consider ways to involve others in initiating change, and then, take the steps to make a difference. Many other providers also want to make a difference, and you may find it easier to connect with them than you imagined. Healthcare organizations are now more receptive and willing to listen and learn about the ideas behind changing and improving critical care. Senior-level administrators do not have the insight or expertise to initiate successful change in ICUs. It is up to the front-line providers to initiate change by gaining the attention of organizational leadership through actions and successes. Nothing needs to start on a large scale. Start small, grow, solicit assistance, and begin your own processes of **Learn It, Deliver It, Measure It, Improve It.** Remember, SCCM is here to provide the framework and to be the community supporting and guiding your efforts.

As another example, I am proud to remember how SCCM quickly became involved with the Institute for Healthcare Improvement's (IHI) "*Save 100,000 Lives Campaign*," which will continue until June 2006. Five of the six primary campaign components are related to critical care, including optimal acute myocardial infarction management, the prevention of ventilator-acquired pneumonia, the adoption of measures to prevent central venous catheter infections, the prevention of adverse drug events, and the initiation of medical response teams to prevent patients from sustaining complete cardiopulmonary arrest during routine hospitalization. The sixth component is the prevention of surgical site infections. The Society is a strong supporter of the Institute for Healthcare Improvement campaign, and I encourage you to approach your hospital and healthcare system leadership groups to make sure they are aware of this important campaign. If you cannot obtain full-scale support for these types of initiatives from your administration, please remember that small group efforts are still effective ways to make a difference, and SCCM will be available to assist you in those efforts.

We are shifting from an historical products-based healthcare industry to a process-based era of health care (Fig. 3). We must all prepare for change and pay attention to the evolving processes for system change. This includes learning new languages and new skills so that we can continue to effect positive change for critical care, regardless of who is looking or trying to influence our environment. Some of this new language and skills include terms such as the following:

- Design Science
- Lean Organizations
- Scale to Complexity
- Value-Based Leadership
- Cultural Competence
- Microsystems Management
- Integrated Safety Nets

CCM Attributes:	Past:	Present:	Future:
Patient Disease	*Shock, ARDS, ID*	*SIRS & MODS, ID*	*Trauma, ID & Immune*
Clinical Care	*Salvage Care*	*Orthopedic Care*	*Prevention-Modulation*
Provider Types	*MD, RN, occ. RT*	*Specialty MD, RN, etc.*	*CCM-focused NP/PA*
Education Spectrum	*None Formalized*	*Silo Specialties*	*Interdisciplinary*
Manpower Needs	*Few Pioneers*	*Marginal & Plateau'd*	*Uncertain Enrollments*
Research Focus	*First-Aid Support*	*Cascade Arcade*	*Immune, Genes, Tech.*
Resource Utilization	*Non-Discriminatory*	*Misdirected Controls*	*Selective Streamlining*
Outcome Measures	*Non-Existent*	*Experimental Phase*	*Standardized Monitor*
EBM Influences	*Not defined yet!*	*Building the Database*	*Mature & Established*
Technology Access	*Misdistribution*	*Non Uniform*	*Resurgence of Focus*
Industry & Academics	*Academic Focus*	*Industry Penetration*	*Blended Partnerships*
Public Expectations	*Grateful – Appreciative*	*Skeptical Naiveté*	*Educated Satisfaction*
Ethics & End of Life	*Paternalistic Care*	*Malpractice Aware*	*Balanced & Shared*
Models of Care	*Open Unit Chaos*	*Closed or Shared Silos*	*Unified-Comprehensive*
Economic Stability	*Who Cares!*	*Inconsistent at Best*	*Stabilized & Balanced*
Internat'l Variation	*Focused in Few*	*Selective Availability*	*Global Access to Care*
Policy Development	*Pioneer Boundaries*	*Budding Awareness*	*Comprehensive Reform*

Figure 3. Attributes of critical care medicine over time.

• Perfection Across the Continuum

Believe it or not, this is a positive change process, but it is new, foreign, and potentially slow in its ability to truly effect improvements. Many of these new systems engineering experiments ultimately may fail in health care. As we come to understand the faults within health care better, there is now reason beyond the shadow of a doubt that health care is broken, and we need to precipitate change. Change is hard, but change is good, and you can help to make a difference.

Closing Comment

Why should we care to change? It still comes back to the patients, their families, friends, and their communities. We simply owe them the Right Care, Right Now™—always!

As I finish my term as president, I ask you to consider the same questions I proposed at the 34th Critical Care Congress. How do we see ourselves in critical care? How do we see others in critical care? How do we think others see us? Where do we need to go from here? You still may not have answers to these questions, but please continue to pay close attention to your thoughts and consider how you are making a difference today.

The Society is making a difference, you can make difference, and you can help SCCM make a difference. I challenge each of you to become a nidus for change in your environment, to reach out and start the movement to provide the **right care**. I thank you again for the privilege of helping you start making those differences **right now**.

Peter B. Angood, MD, FCCM
President
Society of Critical Care Medicine

Society of Critical Care Medicine
VISION STATEMENT

SCCM envisions a health system in which
all critically ill and injured persons will obtain care
that promotes desired outcomes for individuals and society,
is consistent with emerging knowledge,
and occurs in a humane and respectful manner.

Adopted by the SCCM Council
September 28, 1997