

## Embracing quality in critical care

The Presidential Address from the 27th Educational and Scientific Symposium of the Society of Critical Care Medicine

**T**hank you all for the opportunity to serve as your president for the coming year. I'd like to challenge each of you to go back in time with me to revisit your critical care roots. The destination for each of us is that point in time, that episode that captured your soul and riveted you to critical care. We will then swing back to the present and examine some of the very real challenges that face our critically ill patients today.

My journey begins in 1978, a very important year for me, and for my family. I was a medicine intern that year and, if life weren't hectic enough, my lovely wife Pat and I celebrated the birth of our first child. Our daughter, Lindsey, was born in May of that year during the very best rotation of my then-short medical career. I was assigned to the ICU that May and had a terrific supervising resident who was a couple of years ahead of me, and at that time, I was convinced that he knew everything. In truth, we both knew precious little but we were blessed to work with a team of highly skilled and compassionate critical care nurses, respiratory care practitioners, and pharmacists—each of whom was very experienced in working with rather "green" interns and residents. While I enjoyed the fast pace and the adrenaline rush associated with ICU life, I was the most impressed with the teamwork of the doctors, nurses, respiratory care folks, technicians, pharmacy, clergy—the entire critical care team working together captivated me. The

team's chemistry was just right and, as a result, everything worked. Each of us had an important role to play and we made a positive difference in patient's lives through the quality care that was delivered. I was forever hooked on critical care. Do you remember the moment in your career when you decided that you loved critical care?

In 1979, I attended my first Society of Critical Care Medicine (SCCM) meeting and learned of our primary mission: To secure the highest quality care for all critically ill and injured patients. It's been 20 years and, amazingly, I haven't missed a meeting since. Over time, I've listened to plenty of presidential addresses and I've noticed something: I've noticed that the best leaders are not necessarily those who lay out their litany of opinions and plans. No, I think the best are those who simply begin by *listening*. Listening to *your* concerns, *your* needs, *your* issues and then using the office of the presidency to lead the Society in responding to them. Have you let us know what you're thinking recently? What is your need? What is your vision? We need your ideas to help shape SCCM's future and the future of care of our patients. I ask you to give me that input throughout the year. When you return home, remember to stay in touch with us. Surf the SCCM web site to see what's new and use e-mail to let us know what you're thinking.

SCCM has a proud history of listening and responding. That's why our Society—unlike many others—is growing. The SCCM Membership Department staff tells me that we're pushing 9,400 members and that we've nearly *tripled* our membership over the past decade. That's particularly remarkable growth in a time when most other medical organizations are seeing a declining membership. I believe that SCCM's responsiveness to your needs has stimulated our growth.

Another reason for our growth is the fine educational and scientific programs that SCCM offers. Rich in content and broad in scope, these programs focus on the educational content that you and other members tell us you need. SCCM has revolutionized its Symposium in only three short years and has broken every attendance record in the process. In a few years, SCCM will celebrate the 30<sup>th</sup> anniversary of the Symposium and I'm delighted to announce that, for the first time, the Symposium will be co-chaired by an international member.

SCCM recently responded to basic, worldwide educational needs by developing the Fundamental Critical Care Support (FCCS) Course. This course has been in great demand because of the need for fundamental training in critical care in the United States and elsewhere. Requests for this course have sky-rocketed and the numbers of FCCS courses taught are doubling each year. Since 1997 almost 100 courses have been offered, 22 of them in countries other than the United States. There are now a total of 630 FCCS instructors around the world. The textbook that accompanies the FCCS course has been published in English and in Taiwanese, and will soon be published in Portuguese, Spanish, and Italian.

Our scientific publications that focus on research are further examples of how SCCM responds to its membership. SCCM's excellent journal, *Critical Care Medicine*, is the clear leader in its field. *New Horizons* continues to delve into the clinical and social concerns of our professions. SCCM's support of basic and clinical research initiatives is vital to advancing the frontiers of our professions.

In the past several years SCCM has formed affiliations with numerous domestic and international critical care societies in a collaborative attempt to improve care at home and in distant lands. In the United States, we've

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aggressively taken our message to Washington DC to express our views on many advocacy issues and to demand resources to ensure quality care for the critically ill. Recently, SCCM joined with many of our sister organizations to advocate for adequate reimbursement for intensivists.

SCCM has also partnered with the American College of Chest Physicians to produce the Combined Critical Care Review Course. This new five-day course will premiere in Orlando, Florida, on August 6-10, 1999, and is an excellent way to prepare for board examinations or simply review the field. In addition, SCCM has joined hands across the Atlantic to share educational programming and combined journal editor sessions with the European Society of Intensive Care Medicine.

In the area of practice issues, SCCM has collaborated with the Food and Drug Administration, the National Institutes of Health, and numerous other organizations to produce a comprehensive hemodynamic monitoring course in response to concerns about use of the pulmonary artery catheter. Look for this program in the coming year. SCCM has joined with the American Association of Critical-Care Nurses in the Best Practices Network which promotes information sharing among nurses, physicians and other health care professionals to positively impact the quality of care we deliver. SCCM members asked for guidance in setting up protocols and managing the ICU and the SCCM American College of Critical Care Medicine responded by developing 14 guidelines and practice parameters that are now published as a booklet. I urge all members to become familiar with these SCCM tools and confident in using them to improve the care you provide. Click on the SCCM website for further information.

For the remainder of this address, I'd like to focus on one word from our mission statement and that single word is *quality*. How do we insure quality now in our ICUs? How do we insure that we continue to improve quality as new scientific information comes to the fore? Continued quality improvement requires change. All changes are not necessarily improvements, but all improvements require change.

I recently heard a spectacular plenary address delivered by Don Berwick,

MD, the Chief Executive Officer of the Institute for Healthcare Improvement. Dr. Berwick outlined three important elements in change toward improved quality. First, there needs to be tension for change and a will to do better. In the fast pace and high technologic environment of the ICU, this tension and the will to improve is almost always present. Second, there needs to be a plausible alternative to the status quo via a continuous infusion of new ideas. With all of the creative scientific minds we have in the SCCM membership today, an infusion of new ideas should not be a problem for us. The problem that I do expect critical care practitioners to have in putting what is already known into practice is the third element of change toward improved quality: execution.

To illustrate this statement, I'd like to share a rather personal story about a 33-year old woman named Lori who is a nurse in the hospital in which I work. Lori works on a ward just outside the ICU. The entire ICU team passes by this ward on the way to and from the unit so we all know her quite well—she is in fact, a very good friend, a sweet and vivacious lady with a quick wit and warm smile.

Two years ago, during the winter, Lori was admitted to our hospital with shortness of breath. She was soon transferred to the ICU because of worsening oxygenation. The nasal cannula gave way to an oxygen face mask which, in turn, gave way to intubation and mechanical ventilation. You've seen this picture many times. She developed horrible acute respiratory distress syndrome (ARDS) secondary to a viral pneumonia. Conventional ventilatory techniques gave way to pressure-controlled inverse ratio ventilation and with the permission of her husband Lori was enrolled in one of our clinical investigations in ARDS. During her ICU stay she literally tried to die a dozen times. During the darkest hours, most of us thought she was gone, but we refused to surrender. With dogged determination and quality teamwork, day by day, she slowly began to improve.

You've all seen this in your own practice. Two steps forward, one step back. A chest tube here and, a day or so later, another chest tube there, and so on and so forth. After three months of what can only be described as an ago-

nizing ICU stay, Lori was finally discharged to the hospital ward. Following a short stay in the rehabilitation unit, she went home.

I'm happy to tell you that six months ago Lori returned to work as a nurse on her old ward and was kind enough to give me permission to tell her story. In December, I had ICU call over the holidays and as I was leaving the ICU on Christmas day I saw Lori, who was also working that day, with her husband, Jim, and four-year old son, Lucas, who had come to see her on the ward for a brief visit. We spoke for a moment and I can tell you that the vision of that family together on *that* day was truly the greatest gift of my holiday season.

Do you pause periodically to celebrate your successes? Lori's story is an ICU success story in every sense of the word: a true save. We all need to be proud that she and many, many others like her do survive and return to high quality and productive lives.

Remember that word, *quality*. All members of the critical care team face the challenge of maintaining quality care for our patients. But how in the world is this possible when it seems, we're all being asked to do more with less? It's not likely that any of us can work harder so I guess we're going to have to work smarter. You asked SCCM to help you work smarter. You asked SCCM to give you the tools to do so. SCCM responded by developing Project IMPACT (PI). Now in its third year, PI is our comprehensive ICU data system and is a wonderful tool for outcomes research. PI is designed to give us the yardstick we need to measure and to improve efficiency and overall performance in the ICU. PI is already up and running in close to 60 prestigious intensive care units worldwide. PI is the best tool to not only measure your ICU's performance, but more importantly to improve the care you give to your patients. Project IMPACT is designed to help you work *smarter*.

To illustrate this point, I'd like to go back in time once more, this time way back. Like many of you I was a high school athlete or perhaps more correctly stated, I participated in high school athletics. I was kind of a skinny little kid then, hard to believe by looking at me today. I was a bit too small for football and a bit too short for basketball. But I found my niche on the track

team and became a pole vaulter for the Kirkwood High School Pioneers in St. Louis.

I actually learned quite a lot as a member of that team that years later serves me well as a member of the critical care team. The talent and specific skill set necessary to be a quality shot putter, for example, are significantly different than those required to be a successful pole vaulter, hurdler, or distance runner. Yet each individual has critical importance to the overall performance of the team. In the ICU each team member has critical importance to the patient's outcome. The skill sets of the physician, nurse, pharmacist, and respiratory care practitioner are different, yet the skillful and orchestrated performance of each critical care team member is crucial to achieving the best possible outcomes for our patients.

Other important lessons were learned during my pole vaulting years. Competing in this particular event, I could accurately assess the quality of my efforts with a simple tape measure. I could precisely measure my performance against the performance of my competitors. If I didn't measure up, I could study their techniques. I could adopt the successful aspects of their form as they flew through the air and glided over the cross bar; by doing this, I could improve my own performance and become a more valuable and valued contributor to my team.

How can you judge your performance in the ICU without a tape measure, without some objective measure of the *quality* of your outcomes? How can you determine progress without a baseline? You asked SCCM to give you an ICU tape measure—we responded by developing Project IMPACT. PI allows you to measure your performance and compare it with many of the world's quality ICUs. PI will help you in your mission to improve care to the critically ill, while helping you to become more valued by those who control today's scarce health care dollars. PI allows you to take a proactive approach to care delivery by evaluating what you do and how you can do it better.

Outcomes are the name of the game. *If we don't document our performance and find ways to improve upon it, someone else will attempt to do it for us.* Those administrators in your hospital and in

your managed care organizations who eye your budget line with an arched eyebrow, will attempt to document your performance, for example. When your administrator complains that your ICU is chewing up 15 to 30 percent of the hospital's budget, what can you say? Until now, you've had only your word to give him or her as proof your care is high quality and your unit cost effective. With PI, you can provide marvelous *factual* information that compares severity adjusted mortality and resource utilization of your hospital with nationally accepted norms. With a simple graph, you can prove that your unit provides excellent quality at a lower cost than the facility down the street or across town. This information is a powerful tool to give those who negotiate the contracts that keep our hospitals in business.

But what if your unit's performance is not as good as you'd like? What if your resource consumption is a bit high? Project IMPACT can help there too. PI can give you insight into your own ICU so that you can bring your performance up to where you would like it to be, where you know it *should* be.

As President of SCCM, what is my vision for you, for me, for our organization, and for our patients in 1999 and into the next century? It is to embrace quality improvement and understand that it will require continuous change. Please take this message to heart and make it the core of what you are about in the ICU. And with this message comes a challenge. I would like for each of you to do one or more of the following in the next year:

Commit yourself to spending at least one full day in another ICU that utilizes Project IMPACT—see PI in action!

Take a course on continuous process improvement or quality management.

Select quality metrics for your ICU and publish your performance for all to see (patients, families, staff, and administration).

Challenge yourself to go beyond your current paradigms. Step out of the box. Do some "competitive benchmarking" at another institution, discuss new technologies with industry partners, meet with managed care to educate and to learn.

And, finally, learn more about the many programs and projects SCCM has

to offer. Use them to help raise the bar of quality for your patients.

I urge you to periodically pause and remember what brought you to critical care. Being part of a high quality team in a setting that makes a dramatic difference is what did it for me *then*, and does it for me *now*. When we chose to be health care professionals, we chose a way of life that by its very definition is dedicated to change and evolution. Continued improvement in the quality of critical care is not only possible, it's obligatory. I firmly believe that the greatest tragedy is indifference. That's why I ask for your help, your will, your desire to continue to improve the quality of care we deliver to our patients. We need your continued infusion of ideas about how to improve care: ideas from the bench, from the podium, and from the bedside. Most importantly, we need your determination to help improve the systematic delivery of patient care as we strive to ever move the bar upward in better serving our patients. If we do this well, patients like my friend Lori can continue to return from death's doorstep to their families.

I'd be remiss if I didn't thank several people who've helped me in making this presidential year a reality—friends and family who are here to share this special day with me. As I previously mentioned, the mission of our organization is to secure the highest quality care for all critically ill and injured patients. I must first say that we at the SCCM are blessed to have a staff who are not only fundamentally dedicated to this mission but who are also a group of thought provoking, inspiring, and truly visionary professionals. I would like to thank each and every one of you in the SCCM office for all you do.

I also need to thank my good friends and colleagues Phil Dellinger, Janice Zimmerman, Chris Farmer, Steve Trotter, George Matuschak, Joe Civetta, and Bob Kirby. I'd also like to thank our departmental administrator Carolyn Linenbroker, and Critical Care research coordinator Jackie O'Brien—without these two my life, I guarantee you, would be utter chaos.

There are so many other professors, mentors, partners, colleagues and friends I'd like to thank. Way, way too many to name. Instead, in

