



Patient Focused Critical Care Enhancement Act Questions and Answers

What is "critical care"?

Critical care medicine involves the direct delivery of medical care to patients suffering from an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.

How does critical care differ from trauma or emergency care?

Patients who suffer a major traumatic injury (e.g. automobile accident or gunshot wound) would often be considered to be critically ill, but critical care involves a much broader array of conditions, including various "end of life" illnesses that do not involve a traumatic injury. For example, patients suffering through the late stages of such acute illnesses as emphysema, cancer and chronic obstructive pulmonary disease (to name a few) would be considered to be critically ill and in need of critical care services.

Who receives critical care services? Is demand for these services increasing?

Critical care services are overwhelmingly consumed by patients over the age of 65. As the population continues to age, the demand for critical care services is rising and is expected to continue to rise sharply.

Where are critical care services delivered?

While critical care services might be involved in care provided in locations such as a hospice or nursing home, a substantial amount of critical care medicine is delivered in the hospital intensive care unit (ICU) setting. An ICU is a unit within a hospital that is staffed and equipped to deliver the level of care that a critically ill patient requires. An ICU patient would typically require much closer supervision, be receiving many more procedures and be treated with more technology and equipment than a standard hospital patient. In 2000, an estimated 18 million inpatient days of ICU care were provided in the United States through approximately 59,000 ICU beds in 3,200 hospitals. There are significant variations with regard to the arrangement, staffing, size and use of technology in intensive care settings in hospitals throughout the United States.

What types of medical professionals provide critical care services? Is specialized training or experience required?

Critical care medicine is provided by physician-directed multidisciplinary teams consisting of nurses, RTs, pharmacists, and PAs. Critical care medicine has evolved into a board-certified

medical subspecialty that trains physicians to utilize a unique combination of skills needed to care for critically ill patients. Board-certified critical care specialists come from a variety of specialty backgrounds. Most of these physicians come from the internal medicine subspecialty of pulmonology. Other specialties that also practice critical care include anesthesiology, surgery, and pediatrics.

What is an "intensivist"?

Many physicians and other professionals with advanced training in critical care medicine may provide care in a variety of settings and spend only a portion of their time in an ICU. The term "intensivist" is used to describe a physician who is specifically trained in critical care medicine and who provides the majority of their care in an ICU setting. Some intensivists are also "hospitalists", meaning that they practice exclusively within a hospital ICU setting.

Is there a relationship between the level of expertise and training of critical care professionals, and the amount of time they spend providing critical care services in the ICU setting, and health care outcomes and quality?

Yes. Studies of critical care services have clearly demonstrated improvements in outcomes and efficiency when intensive care services are provided by physicians specifically trained in critical care medicine who provide the majority of their care in an ICU setting ("intensivists") and by nurses with advanced specialty training in critical care medicine. As a result, health care payors and providers are encouraging greater use of such personnel in intensive care settings. The Leapfrog Group, for example, has recommended that ICU services be provided by intensivists.

Given that the demand for critical services is expected to continue to rise as a result of the aging of the population, and that the quality and efficiency of such services improves when provided by dedicated professionals with specialized training, especially, intensivists, is there an adequate supply of such health care providers?

The current supply of trained critical care physicians in the United States is inadequate to meet the accelerating demand for such services; moreover, the Health Resources & Services Administration has projected that the future growth in the number of critical care physicians in ICU settings will be insufficient to keep pace with growing demand. Currently, only 1 in 3 ICU patients is under the care of an intensivist. This growing shortage of critical care providers presents a serious threat to the quality and availability of health care services in the United States. Moreover, this shortage will disproportionately impact rural and other areas of the United States that already often suffer from a sub-optimal level of critical care services.

What can be done to address the growing shortage of health care providers with advanced training in critical care medicine and the need for more intensivists?

The problem can be addressed through a combination of measures to address both the supply and demand for critical care providers. As set out below, the Patient Focused Critical Care Enhancement Act proposes some modest steps to address this.

In addition to addressing the supply of and demand for critical care services, are there other steps that can be taken to address this problem?

Yes. Research suggests that modifications in staffing, the organization and arrangement of ICUs and utilization of advanced technology can improve the efficiency and quality of critical care services. The Patient Focused Critical Care Enhancement Act proposes a modest research program to explore and develop these innovations.

Given that critical care services are often delivered to individuals over the age of 65 whose family members (e.g., spouse, children, grandchildren) may be extensively involved in the process, are there steps that can be taken to improve the experience for everyone involved?

Yes. Too often, family members of critically ill individuals report intense dissatisfaction with the manner in which care is provided to their loved ones. This is often a result of a failure to adequately communicate with family members regarding the patient's status, the necessity for certain procedures or approaches, and possible outcomes. This can result in family members feeling confused, alienated and resentful. Models of care that embrace a "family centered" approach to critical care in which communication barriers are pro-actively addressed have shown great promise. The Patient Focused Critical Care Enhancement Act proposes a demonstration initiative to validate the merits of the "family centered" approach.

What does the Patient Focused Critical Care Enhancement Act do?

The Act proposes a number of steps to try to address the current and growing shortage of critical care providers, including:

- Authorizing a research program whereby HHS would review all current research on critical care to ascertain "best practices" in critical care with regard to standardizing protocols, layouts, equipment interoperability and medical informatics as well as a study of how differences in staffing, organization and size of ICUs affect quality and efficiency. This research would provide a road map for the improvement of ICU services.
- Authorizing two demonstration projects to be undertaken by HHS:
 - a CMS-administered demonstration on innovations in ICU services; the idea behind this demonstration would be to apply some of the best practices recognized through research in an actual clinical care setting to prove their effectiveness;
 - a demonstration to pilot and evaluate a family-centered, multi-disciplinary approach to critical care services. As discussed above, this is an important way to improve the quality of the care experience for everyone involved. The

demonstration would focus on identifying practical tools to help implement such programs in a variety of settings.

- Authorizing expanded telemedicine efforts to link rural critical care providers with the services and expertise available in larger institutions by amending the Department of Agriculture's Distance Learning and Telemedicine program to authorize an extra \$5,000,000 to support efforts by rural providers of inpatient critical care to improve services through telecommunications linkages to other providers in more populous areas. The Act also amends HHS' Telehealth Network Grant program to make such programs eligible for funding.
- Authorizing efforts to recruit, place and retain critical care providers in medically underserved areas to address the shortage of such personnel. The National Health Service Corps Act provides for incentive grants and loan repayment programs to encourage health professionals to take jobs in "medically underserved areas" (usually rural or inner city areas). This Act would create an express authorization for a program to recruit not less than 50 critical care providers per year to provider services in medically underserved areas in exchange for loan repayment assistance.

Does this bill amend Medicare or Medicaid?

No. The legislation is limited to amending several public health service act programs as well as expanding telemedicine authorization.

What is the budgetary impact of this legislation?

The bill makes no changes to any federal entitlement programs (and thus has no "Pay-As-You-Go" scorekeeping implications under the federal budget process), but it does authorize appropriations for research and demonstrations and for a slight expansion of the telemedicine programs and the National Health Service Corps program. These changes would have to be funded by the appropriations committee. These new authorizations total about \$20 million.

How can members of Congress support this effort?

We are asking that they co-sponsor (sign their name to) the legislation that has been introduced in the House and the Senate (S. 718 and H.R. 3886). S.718 was introduced by Senator Richard Durbin (D-IL) on February 28, 2007. Senator Mike Crapo (R-ID) was an original co-sponsor. H.R. 3886 was introduced by Representative Jan Schakowsky on October 18, 2007. Representative Eric Cantor (R-VA) was an original co-sponsor. See attached list of co-sponsors (as of March __, 2008).