

Vision for Critical Care Medicine at DHMC

Guiding Principles:

- There is a core common fund of knowledge common to all practitioners of Critical Care Medicine, whatever their training pathway.
- There are unique areas of expertise within the various sub-disciplines.
- The optimal model of multidisciplinary care delivery takes full advantage of both of these strengths, enhancing quality of care and of teaching.
- The intensivist is the leader of the primary bedside minute-to-minute care.

Proposed actions:

1. The common body of knowledge among all critical care physicians ensures that any patient admitted at any time of day will be cared for in an appropriate fashion in accordance with all acceptable standards of care. Nevertheless, liberal consultation, at any hour should be encouraged. In order to provide the highest quality of teaching and optimal patient care, patients shall be triaged the following morning after admission to the team whose focus best meshes with the problems of the patient. A scheme for dividing the 3 teams into disease-focused groups is shown below:

Teams	Team 1 Thoracic	Team 2 Multidisciplinary	Team 3 Trauma
Patients	Pulmonary, pleural, Heme/Oncology Immunocompromised Hospitalist-ICU		Trauma Neuro-trauma
		Non – Trauma General Surgical CT & Vascular Surgical	
		GI bleed, pancreatitis, sepsis, ARDs	
Team Directors	Enelow	Surgenor	Burchard
Faculty Primary Focus			
Faculty Secondary Focus			

The details and specifics of resident and fellow coverage shall be worked out by the program directors, with regular review and refinement over time.

One team director from the critical care faculty will be appointed for each of the three physiologically based teams. A job description with clear expectations will be created for this position. These leaders will participate in the ICU Committee (http://policy.hitchcock.org/dspPolicyWindow.cfm?policy_id=155) that will manage and direct

- a. quality assurance & patient safety;
 - b. critical care practice & policy;
 - c. development & maintenance of protocols;
 - d. the closing of order sets;
 - e. transformation toward the electronic health record;
 - f. co-round system; and
 - g. physiology-based educational materials;
2. A joint rounding process will be initiated that will require surgical services and the CCS service to co-round on patients between 6:30 and 7:30 each morning and cooperatively develop a care plan for the day.
 3. Close order sets to CCS team
 - a. All patients, all the time
 - i. Allow surgical teams to write admission & post -op orders.
 - ii. Emergent exceptions.
 - b. Compatible with current co-attending, when combined with #1 (see above)
 4. Monitor the use of evidence based protocols
 - a. ARDsNET
 - b. Glucose control
 - c. Sedation
 - d. Rapid Antibiotics
 - e. Fluid resuscitation
 - f. Steroid Protocol
 - g. Antibiotic Stewardship
 - h. Family Meetings
 - i. DVT Prophylaxis
 - j. ICP Management
 5. Refine "job description" for Critical Care Faculty
 - a. When functioning as primary attending caregivers for CCS patients, CCS faculty are NOT permitted to perform elective procedures outside the critical care patient population, take call for another service, or otherwise be unavailable.
 - b. CCS faculty should be prepared to assume fellow or resident level duties when during time devoted to CCS service.
 - i. Coverage of some resident level call to be expected in 2009.

- c. CCS faculty must be in compliance with billing regulations.
- d. There will be no tolerance of unprofessional behavior, including derogatory remarks about the character or judgment of other CCS attendings.
 - i. A member of Human Resources will be identified who would investigate any such behaviors and report their findings to the responsible Section Chief(s) and Department Chair.
- e. Educational Activities
 - i. Faculty will attend CCS fellowship lectures and conferences.
 - ii. Faculty will complete evaluations
 - 1. Of residents
 - 2. Of program
 - 3. Of medical students
 - iii. Faculty are expected sign off to each other at the end of rotations.
 - iv. Repeated unsatisfactory teaching evaluations from trainees may be grounds for suspension of privileges.

Failure to meet any of the expectations of the job description may result in loss of Critical Care Privileges, at the discretion of the oversight committee (see below).

6. Governance

As a clinical service, and for day-to-day management and performance to budget, the Critical Care Service will report to the Chairman of the Department of Anesthesiology.

When physicians are on the critical care service, their primary reporting relationship is to the Section Chief of Critical Care.

As a multidisciplinary center, the Critical Care Service and the ICU shall be accountable to an Oversight Committee consisting of the Chairs of the Departments of Medicine, Surgery and Anesthesiology, as well as the Executive Medical Director. This committee will meet quarterly, and have full and formal responsibility for ensuring the highest level of professionalism among the faculty from all Departments, as well as the highest quality of patient care and education.