

CRITICAL CARE SOCIETIES COLLABORATIVE (CCSC)



August 15, 2022

The Honorable Patty Murray
Chair, Committee on Health, Education, Labor, and
Pensions
United States Senate
154 Russell Senate Office Building
Washington, DC 20510

The Honorable Richard Burr
Ranking Member, Committee on Health, Education,
Labor, and Pensions
United States Senate
217 Russell Senate Office Building
Washington, DC 20510

Dear Chair Murray and Ranking Member Burr:

On behalf of the Critical Care Societies Collaborative (CCSC), representing nearly 200,000 multidisciplinary and multiprofessional critical care professionals, we are writing to express our support for S. 3799, the Prepare for and Respond to Existing Viruses, Emerging New Threats, and Pandemics Act (PREVENT Pandemics Act). We thank you for your bipartisan leadership in addressing the need to examine the COVID-19 response and enact measures that will prepare the United States to identify and respond effectively to future infectious disease outbreak and pandemics, including strengthening America's domestic medical supply chain, the creation of the Advanced Research Project Authority for Health to spur innovation, and improving our ability to predict future emergencies.

Still, there is more to be done. We urge Congress to enhance its response by addressing the strain the COVID-19 pandemic has placed on the critical care workforce and ensure support for the most vulnerable patients in need of acute care.

Supporting the Critical Care and Acute Care Workforce

Most important is the need to address the impact of an exhausted and depleted acute care workforce. Dire shortages of critical care workers, including nurses, respiratory therapists, and physicians, are emerging. These staffing problems predate the pandemic but have been greatly exacerbated by over two years of bearing witness to suffering on an unprecedented scale in recent American history. Expertise in critical care requires years of experience, making it necessary to nurture and support the pipeline now, not at the time of a disaster.

In addition to the number of trained personnel, there are also problems of distribution. Critical care staff tend to be concentrated in major urban areas. During the pandemic, underserved communities throughout rural America have been rapidly overwhelmed, with limited ability to surge in response to increased patient demand.

With these concerns in mind, we respectfully recommend the following:

1. Create a pathway to support training for an acute care surge workforce, analogous to existing programs to support primary care in underserved areas (e.g., the National Health Service Corps Scholarship Program and Health Resources and Services Administration's Nurse Corps).
2. Work with health systems to address imbalances in staff compensation. For example, nurses and respiratory therapists often leave hospital employment for travel assignments (which is their right), where they receive increased compensation and more flexible hours. Hospitals then find themselves paying even more money to travel staffing agencies to maintain the same staffing with less stability. Better compensation for their experienced core staff would be a simpler and more stable solution.

3. Develop programs to support acute care workforce resiliency and well-being, in order to maintain a stable and prepared workforce for emergencies.
4. Maintain a robust and well-trained Army, Navy, Air Force, and Public Health Service (PHS) workforce to allow for a reliable force of uniformed personnel to provide emergency hospital support.

Enhancing the Medical Supply Chain

Early in the pandemic, equipment shortages were anticipated to be the major limiting feature of the pandemic (e.g., ventilators, continuous renal replacement therapy circuits), along with personal protective equipment (PPE). These issues have been largely addressed. Despite this, ongoing shortages of consumable items, including key medications such as IV sedatives and vials for the collection of patient blood specimens, remain chronic impediments to the care of hospitalized patients.

The National Defense Production Act was invoked to manufacture ventilators, but only 60,000 out of 200,000 produced were true full-featured ventilators that could support a patient with acute respiratory distress syndrome (Branson R, et al. *Chest*. 2021;159:634-652). Future federal efforts to boost emergency production need to be made with expert clinical input to ensure that the equipment being produced meets actual clinical needs, unlike the majority of these ventilators.

In light of the PREVENT Pandemics Act's intent to improve our national emergency stockpiles and domestic production of critical medical equipment, we respectfully suggest the following:

- Encourage the development of reusable PPE to reduce vulnerability on supply chain disruption in times of crisis (e.g., elastomeric N95 respirators, reusable gowns).
- Focus on capabilities rather than specific pieces of equipment.
- Manage the distribution of critical items in shortage in a rational, transparent, and equitable manner.
- Recommend the creation of a multidisciplinary group of critical care and respiratory therapy experts to guide the development of the next generation of emergency ventilators for the Strategic National Stockpile, specifically to ensure that these devices will be capable of supporting patients with acute hypoxemic respiratory failure.
- Ensure that hospitals and health systems maintain plans for expansion of acute care spaces (e.g., post-anesthesia care units, emergency departments, tent facilities) and drill their plans regularly.

Regional Networks and Crisis Standards of Care

There is strong evidence that patient mortality increases when hospitals are overwhelmed with large numbers of critically ill patients that exceed their routine capacity (Kadri SS, et al, *Ann Intern Med*. 2021;174:1240-1251). Load-leveling, a structured system to transfer patients from more- to less-overwhelmed facilities, has the potential to reduce mortality. Some jurisdictions have successfully created mechanisms for load-leveling during public health emergencies that reach beyond individual hospital systems (e.g., the Northwest Healthcare Response Network in Washington State), but they are uncommon. Normal competition among hospitals can become a barrier to care in these settings. Regional and national networks need to be established for coordinating patient loads, sharing clinical data, and managing supply shortages among health systems in a rapid and transparent manner during public health emergencies, along the lines of the National Special Pathogens System of Care (NSPS) under development by the National Emerging Special Pathogens Training and Education Center (NETEC).

Multiple regions of the United States have needed to institute crisis standards of care, with the possibility of limiting the provision of critical care resources to patients unlikely to survive. There are no existing national standards for crisis standards of care, although several well-reasoned protocols exist. Controversy about inequities

continues to affect these systems, as well as limitations in the ability to predict survival in pandemic victims accurately.

Telehealth services have improved the ability to provide care in hard-hit regions where critical care expertise may be limited. In a public health emergency, licensure issues may limit the ability to provide care across state lines. Mechanisms exist to waive these requirements in emergencies, but they may not be well coordinated or rapid. While acknowledging the need for state boards to regulate the practice of medicine, nursing, pharmacy, and other health professions within their jurisdictions, pandemics and other public health emergencies do not respect state or national borders. Continued support for telehealth expansion is necessary to ensure adequate care.

Given these concerns regarding crisis care and inequity, we respectfully suggest the following:

- Support the development of regional and state networks that cross the boundaries of existing hospitals and health systems, ensuring open data sharing on resource availability during emergencies and providing a mechanism for patient transfer from more-burdened to less-burdened centers, with a goal of reducing mortality.
- Develop national ethical and operational standards for crisis standards of care, updating the preexisting 2009 Institute of Medicine guidance (Institute of Medicine. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. National Academies Press; 2009).
- Ensure that any such standards acknowledge the impact of prior health inequities in resource allocation, with attention to the needs of underserved minority groups, people living with disabilities, and other marginalized groups.
- Building on the success of the National Institutes of Health's COVID-19 clinical guidelines, ensure that a mechanism exists for the rapid synthesis of scientific data into easily accessible guidelines.
- Ensure continued support for telehealth services in reimbursement and provide mechanisms to simplify the provision of such services across state lines.

Biosafety and Biomedical Research

Federally supported research has been critical during the pandemic, including but not limited to the rapid and extraordinary development of effective vaccines and Adaptive COVID-19 Treatment Trial (ACTT) and Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) clinical trial networks. The PREVENT Pandemics Act provides robust support for biomedical research. We are grateful for your leadership in this regard and optimistic that increased support for therapeutic and diagnostic system development and the further growth of clinical trial networks will lead to improved care in the future.

We have been saddened by the increasing polarization of science vs patients' individual beliefs in the pandemic. Critical care professionals have borne the brunt of this polarization more than most, often struggling to care for dying patients who deny the existence of the disease that is actively killing them. The normal back-and-forth of scientific discovery and debate has been exploited as inconsistency or simple untruths by purveyors of misinformation. As clinicians dedicated to caring for the sickest of patients, regardless of their beliefs or circumstances, we believe it is critical that our national biomedical research establishment develop tools to increase scientific literacy and better communicate public health recommendations with our fellow citizens.

At the time of this writing, the United States passed a grim milestone, the millionth death due to COVID-19. We are hopeful that we are transitioning, in Dr. Fauci's words, out of the acute phase of the pandemic. The recency of the COVID-19 pandemic should prompt significant and ongoing support to ensure that our country is better equipped

Murry and Burr Letter

August 10, 2022

Page 4 of 4

to respond to future pandemics. Our lives, and those of future generations of Americans, are depending on it.

Thank you once again for your leadership and support.

Sincerely,

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