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(Original Signature of Member)

112TH CONGRESS  
1ST SESSION

**H. R.** \_\_\_\_\_

To improve the understanding and coordination of critical care health services.

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IN THE HOUSE OF REPRESENTATIVES

Ms. BALDWIN introduced the following bill; which was referred to the  
Committee on \_\_\_\_\_

\_\_\_\_\_  
**A BILL**

To improve the understanding and coordination of critical  
care health services.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Critical Care Assess-  
5 ment and Improvement Act of 2011”.

6 **SEC. 2. FINDINGS; PURPOSES.**

7 (a) FINDINGS.—Congress finds the following:

8 (1) Critical care medicine is the care for pa-  
9 tients whose illnesses or injuries present a signifi-

1       cant danger to life, limb, or organ function and re-  
2       quire comprehensive care and constant monitoring,  
3       usually in intensive care units.

4           (2) Each year, approximately five million Amer-  
5       icans are admitted into traditional, surgical, pedi-  
6       atric, or neo-natal intensive care units.

7           (3) Nearly 80 percent of all Americans will ex-  
8       perience a critical care injury or illness as a patient,  
9       family member, or friend of a patient.

10          (4) Critical care medicine consumes a signifi-  
11       cant amount of financial resources, accounting for  
12       more than 13 percent of all hospital costs.

13          (5) According to a 2006 report by the Health  
14       Resources and Services Administration (“HRSA”),  
15       demand in the United States for critical care med-  
16       ical services is on the rise, due in part to the grow-  
17       ing elderly population, as individuals over the age of  
18       65 consume a large percentage of critical care serv-  
19       ices.

20          (6) The HRSA report also found that the grow-  
21       ing aging population will further exacerbate an exist-  
22       ing shortage of intensivists, the physicians certified  
23       in critical care who primarily deliver care in inten-  
24       sive care units, potentially compromising the quality  
25       and availability of care.

1           (7) The demand on critical services and trained  
2           personnel increases exponentially in the event of a  
3           natural disaster or pandemic outbreak such as the  
4           H1N1 virus.

5           (8) Ensuring the strength of our critical care  
6           medical delivery infrastructure is integral to the im-  
7           provement of the quality and delivery of health care  
8           in the United States.

9           (b) PURPOSE.—The purpose of this Act is to assess  
10          the current state of the United States critical care medical  
11          delivery system and implement policies to improve the  
12          quality and effectiveness of care delivered to the critically  
13          ill and injured.

14       **SEC. 3. STUDIES ON CRITICAL CARE.**

15          (a) INSTITUTE OF MEDICINE STUDY.—

16               (1) IN GENERAL.—The Secretary of Health and  
17               Human Services (in this Act referred to as the “Sec-  
18               retary”) shall enter into an agreement with the In-  
19               stitute of Medicine under which, not later than 1  
20               year after the date of the enactment of this Act, the  
21               Institute will—

22                       (A) conduct an analysis of the current  
23                       state of critical care health services in the  
24                       United States;

1 (B) develop recommendations to bolster  
2 critical care capabilities to meet future demand;  
3 and

4 (C) submit to Congress a report including  
5 the analysis and recommendations under sub-  
6 paragraphs (A) and (B).

7 (2) ISSUES TO BE STUDIED.—The agreement  
8 under paragraph (1) shall, at a minimum, provide  
9 for the following:

10 (A) Analysis of the current critical care  
11 system in the United States, including—

12 (i) the system's capacity and re-  
13 sources, including the size of the critical  
14 care workforce and the availability of  
15 health information technology and medical  
16 equipment;

17 (ii) the system's strengths, limitations,  
18 and future challenges; and

19 (iii) the system's ability to provide  
20 adequate care for the critically ill or in-  
21 jured in response to a national health  
22 emergency, including a pandemic or nat-  
23 ural disaster.

24 (B) Analysis and recommendations regard-  
25 ing regionalizing critical care systems.

1 (C) Analysis regarding the status of crit-  
2 ical care research in the United States and rec-  
3 ommendations for future research priorities.

4 (b) GOVERNMENT ACCOUNTABILITY OFFICE  
5 STUDY.—Not later than 1 year after the date of the enact-  
6 ment of this Act, the Comptroller General of the United  
7 States shall issue a report including the following:

8 (1) An inventory of all current and recent crit-  
9 ical care research and critical care-related programs  
10 of the Federal Government and recommendations on  
11 how to better coordinate critical care research ef-  
12 forts.

13 (2) An economic analysis of critical care costs  
14 as a percentage of overall Federal health care spend-  
15 ing, and a comparison of such percentage to the per-  
16 centage of Federal critical research expenditures rel-  
17 ative to overall Federal health research spending.

18 (c) HEALTH RESOURCES AND SERVICES ADMINIS-  
19 TRATION STUDY.—

20 (1) IN GENERAL.—The Secretary, acting  
21 through the Administrator of the Health Resources  
22 and Services Administration, shall review and update  
23 the Administration's 2006 study entitled "The Crit-  
24 ical Care Workforce: A Study of the Supply and De-  
25 mand for Critical Care Physicians".

1           (2) SCOPE.—In carrying out paragraph (1), the  
2       Secretary shall expand the scope of the study to ad-  
3       dress the supply and demand of other providers  
4       within the spectrum of critical care delivery, includ-  
5       ing critical care nurses, mid-level providers (such as  
6       physician assistants and nurse practitioners), inten-  
7       sive care unit pharmacists, and intensive care unit  
8       respiratory care practitioners.

9       **SEC. 4. NIH CRITICAL CARE COORDINATING COUNCIL.**

10       (a) ESTABLISHMENT.—The Secretary, acting  
11       through the Director of the National Institutes of Health,  
12       shall establish a council within the Institutes to be known  
13       as the Critical Care Coordinating Council (in this section  
14       referred to as the “Council”).

15       (b) MEMBERSHIP.—The Secretary shall ensure that  
16       the membership of the Council includes representatives of  
17       each of—

18           (1) the National Heart, Lung, and Blood Insti-  
19       tute;

20           (2) the National Institute of Nursing Research;

21           (3) the Eunice Kennedy Shriver National Insti-  
22       tute of Child Health and Human Development;

23           (4) the National Institute of General Medical  
24       Sciences;

25           (5) the National Institute on Aging; and

1 (6) any other national research institute or na-  
2 tional center of the National Institutes of Health  
3 that Secretary deems appropriate.

4 (c) DUTIES.—The Council shall—

5 (1) coordinate the collection and analysis of in-  
6 formation on current research of the National Insti-  
7 tutes of Health relating to the care of the critically  
8 ill and injured, identify gaps in such research, and  
9 make recommendations to the Director of such Insti-  
10 tutes on how to improve such research; and

11 (2) provide annual reports to the Director re-  
12 garding research efforts of the National Institutes of  
13 Health relating to the care of the critically ill and  
14 injured, and make recommendations in such reports  
15 on how to strengthen partnerships within the Na-  
16 tional Institutes of Health and between the National  
17 Institutes of Health and public and private entities  
18 to expand collaborative, cross-cutting research.

19 **SEC. 5. IMPROVING FEDERAL DISASTER PREPAREDNESS**  
20 **EFFORTS TO CARE FOR THE CRITICALLY ILL**  
21 **AND INJURED.**

22 (a) REPORT ON AVAILABILITY OF CRITICAL CARE  
23 PRACTITIONERS.—Not later than 1 year after the date of  
24 the enactment of this Act, the Secretary shall submit a  
25 report to the Congress on the adequacy of the number of

1 critical care practitioners in disaster medical assistance  
2 teams, the Medical Reserve Corps, and the Public Health  
3 Service Commissioned Corps. Such report shall include  
4 recommendations, as necessary, for addressing any short-  
5 ages in the number of such practitioners.

6 (b) GUIDELINES OR BEST PRACTICES FOR EMER-  
7 GENCY ICU EVACUATION PRACTICES.—

8 (1) DEVELOPMENT.—Not later than 1 year  
9 after the date of the enactment of this Act, the Sec-  
10 retary, acting through the Director of the Agency  
11 for Healthcare Research and Quality and the Assist-  
12 ant Secretary for Preparedness and Response, in  
13 consultation with critical care practitioners, shall de-  
14 velop guidelines or best practices for the evacuation  
15 of intensive care units during a national health  
16 emergency, including a pandemic or natural disaster.

17 (2) REQUIREMENT.—The Secretary shall design  
18 the guidelines and best practices under paragraph  
19 (1) so as to ensure the safe and effective evacuation  
20 of all individuals regardless of age, disability, or life  
21 expectancy.

22 (c) PANEL ON EMERGENCY PREPAREDNESS DATA-  
23 BASES.—

24 (1) ESTABLISHMENT.—The Secretary shall es-  
25 tablish a panel of emergency preparedness experts to

1 be known as the Panel on Emergency Preparedness  
2 Databases (in this section referred to as the  
3 “Panel”).

4 (2) MEMBERSHIP.—The Secretary shall ensure  
5 that the membership of the Panel includes experts  
6 from the public and private sector and experts from  
7 the critical care community.

8 (3) DUTIES.—The Panel shall—

9 (A) assess the adequacy of existing na-  
10 tional preparedness databases in facilitating ef-  
11 fective and coordinated local, State, and Fed-  
12 eral medical responses during a national health  
13 emergency, including a pandemic or natural dis-  
14 aster;

15 (B) identify gaps in existing information  
16 networks;

17 (C) recommend specific ways to improve  
18 awareness of the availability of resources before,  
19 during, and after an incident; and

20 (D) submit to the Secretary a report in-  
21 cluding the assessment, identification, and rec-  
22 ommendations made under subparagraphs (A)  
23 through (C), respectively.

1 **SEC. 6. LIMITATION ON USE OF FINDINGS AND REC-**  
2 **COMMENDATIONS IN OTHER PROGRAMS.**

3 (a) PROHIBITION.—In making coverage, reimburse-  
4 ment, or incentive determinations under any program, the  
5 Secretary may not use any finding or recommendation de-  
6 veloped under this Act—

7 (1) in a manner that precludes an individual  
8 from choosing a health care treatment based on how  
9 the individual values the tradeoff between extending  
10 the length of life and the risk of disability; or

11 (2) with an intent to discourage an individual  
12 from so choosing a health care treatment.

13 (b) RULE OF CONSTRUCTION.—Subsection (a) shall  
14 not be construed to prevent the issuance by the Secretary  
15 of a finding or recommendation addressing differences due  
16 to a patient's age, disability, or terminal illness in the ef-  
17 fectiveness of alternative health care treatments that may  
18 extend the patient's life.