DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF PROPOSED RULEMAKING

DOCKET NUMBER 03-83-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b), hereby gives notice of the intent to amend the Vehicle and Traffic Regulations (18 DCMR). Final rulemaking action shall be taken in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

The following rulemaking action is proposed:

Title 18 DCMR, Section 4004, ONE-WAY STREETS, Subsection 4004.1, (d) Southeast Section, is amended by adding the following to the list of locations where traffic is restricted to one direction of travel:

"Stanton Road, S.E., between Trenton Place and Mississippi Avenue, for northbound traffic only".

Title 18 DCMR, Section 4008, STOP SIGNS, Subsection 4008.1, (d) Southeast Section, is amended by deletion the following from the list of locations where the Director has authorized the placement of STOP signs:

"On Stanton Road, S.E., so as to stop at Mississippi Avenue".

All persons interested in commenting ton the subject matter in this proposed rulemaking action may file comments in writing, not later that thirty days (30) after the publication of this notice in the D.C. Register, with the Department of Transportation, Traffic Services Administration, 2000 14th Street, N.W., 7th Floor, Washington, D.C. 20009 (Attention: Docket No. 03-83-TS). Copies of this proposal are available, at cost, by writing to the above address.

DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth under § 302(14) of the D.C. Health Occupations Revision Act of 1985, effective March 15, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1203.02(14)), and Mayor's Order 98-140, dated August 20, 1998, hereby gives notice of his intent to take final rulemaking action to adopt the following amendments to Chapter 67 of Title 17 of the District of Columbia Municipal Regulations (DCMR) in not less than thirty (30) days from the date of publication of this notice in the D.C. Register. The purpose of the proposed rules is to make the District regulations comparable to the regulations in the 2002 Model Practice Act for Physical Therapy promulgated by the Federation of State Boards of Physical Therapy.

Chapter 67 (Physical Therapy) of Title 17 DCMR (Business, Occupations & Professions) (May 1990) is amended as follows:

6702 EDUCATIONAL REQUIREMENTS

Section 6702.1 is amended to read as follows:

6702.1 Except as otherwise provided in this subtitle, an applicant shall furnish proof satisfactory to the Board that the applicant has graduated from a professional physical therapy education program accredited by an agency recognized for that purpose by the United States Department of Education, or which is approved by the Board, in accordance with § 504(j) of the Act (D.C. Official Code § 3-1205.04(j)).

Section 6703 is amended to read as follows:

6703 APPLICANTS EDUCATED IN FOREIGN COUNTRIES

6703.1 The Board may grant a license to practice physical therapy to an applicant who has been educated outside of the United States if the applicant meets the following requirements:

(a) Provides satisfactory proof that the applicant's education is substantially equivalent to the requirements of physical therapists educated in an accredited education program as determined by the Board;

(b) Passes the Board-approved English proficiency examination if the applicant's native language is not English; and

(c) Passes the examination approved by the Board.

6703.2 For purposes of this section, "substantially equivalent" means that the applicant for licensure educated outside of the United States shall have:

(a) Graduated from a physical therapy education program that prepares the applicant to engage without restriction in the practice of physical therapy;

(b) Provided written proof that the applicant's school of physical therapy education is recognized by its own ministry of education or equivalent governmental authority;

(c) Undergone a credentials evaluation as directed by a Board that determines the candidate has met uniform criteria for educational requirements as further established by rule; and

(d) Completed any additional education as required by the Board.

Section 6703.3 is deleted.

The section heading for 6704 is amended to read as follows:

6704 LICENSURE BY EXAMINATION

Section 6704 is amended to read as follows:

6704.1 An applicant for licensure as a physical therapist by examination shall initiate the application process by submitting a completed application together with the appropriate application fee and the documentation required by § 6702.2.

6704.2 An applicant for licensure as a physical therapist shall have pre-approval from the Board before taking any licensure examination.

6704.3 An applicant for licensure by examination must take and pass a Board-approved national licensure examination in physical therapy (the national examination) and a Board-approved District of Columbia licensure examination in physical therapy (the District examination).

6704.4 Following approval from the Board to take the applicable examinations, the applicant may take the national examination and the District examination in any order.

6704.5 The passing score on the national examination shall be determined by the body administering the examination.

6704.6 The District examination shall be a written examination, developed and administered by the Board or a body approved by the Board, on laws and rules pertaining to the practice of physical therapy in the District of Columbia.

6704.7 The District examination may consist of questions on District of Columbia laws pertaining to physical therapy including the Act, this chapter, and chapters 40 and 41 of this title. The passing score on the District examination shall be determined by the Board.

6704.8 An applicant for licensure who does not pass either examination on the first attempt must seek and obtain Board approval for any subsequent attempts to retake the examination. Before the Board may approve an applicant for subsequent testing beyond three (3) attempts, an applicant shall submit proof satisfactory to the Board of having successfully completed any remediation as determined by the Board.

6704.9 If the Board determines that an applicant has engaged in or has attempted to engage in conduct that subverts or undermines the integrity of either the national examination process or District examination process, the Board may disqualify the applicant from taking the examinations. Examples of such conduct may include, but are not limited to the following:

(a) Utilizing in any manner recalled or memorized examination questions;

(b) Failing to comply with all test center security procedures;

(c) Attempting to communicate with other examinees during the test; or

(d) Copying or sharing examination questions or answers or portions of questions or answers.

6704.10 All occurrences of any violations set forth in § 6704.9 shall be recorded in the official records of the Board. Board action may include, but is not limited to, the following:

(a) Disqualifying test results of the applicant's examinations;

(b) Disqualifying the applicant, permanently or for a specified period of time, from eligibility for the examinations;

(c) Disqualifying the applicant, permanently or for a specified period of time, from eligibility for licensure;

(d) Revocation, suspension, or imposition of probationary conditions on a license issued to the applicant.

Section 6705 is deleted and reserved.

Section 6706 is amended to read as follows:

6706 CONTINUING EDUCATION REQUIREMENTS

6706.1 Subject to §6706.2, this section shall apply to applicants for the renewal, reactivation, or reinstatement of a license for a term expiring January 31, 1991, and for subsequent terms.

6706.2 This section shall not apply to applicants for the first renewal of a license granted by examination.

6706.3 A continuing education credit shall be valid only if it is approved by the Board in accordance with § 6707.

6706.4 An applicant for renewal of a license shall submit proof pursuant to § 6706.7 of having completed four (4) continuing education units or forty (40) hours of approved continuing education credit during the two-year period preceding the date the license expires.

6706.5 To qualify for a license, a person in inactive status within the meaning of § 511 of the Act (D.C. Official Code § 3-1205.11) who submits an application to reactivate a license shall submit proof pursuant to § 6706.7 of having completed two (2) continuing education units or twenty (20) hours of approved continuing education credit for each license year after January 31, 1989, that the applicant was in inactive status.

6706.6 To qualify for a license, an applicant for reinstatement of a license that has expired pursuant to § 512(b) of the Act (D.C. Official Code § 3-1205.12(b)) shall submit proof pursuant to § 6706.7 of having completed two (2) continuing education units or twenty (20) hours of approved continuing education credit for each year after January 31, 1989, that the applicant was in an expired status, up to a maximum of ten (10) continuing education units or one hundred (100) hours.

6706.7 An applicant submitting proof of completion of continuing education units shall submit the following information with respect to each program:

(a) The name and address of the sponsor of the program;

(b) The name of the program, its location, a description of the subject matter covered, and the names of the instructors;

(c) The dates on which the applicant attended the program;

(d) The hours of credit claimed; and

(e) Verification by the sponsor of completion, by signature or stamp.

6706.8 If an applicant for renewal of a license fails to submit proof of having completed continuing education requirements by the date the license expires, the applicant shall not practice until his or her license has been renewed.

6706.9 An applicant for renewal of a license who fails to submit proof of having completed continuing education requirements by the date the license expires may renew the license up to sixty (60) days after expiration by submitting proof pursuant to § 6706.7 and paying the late fee.

6706.10 If an applicant for renewal of a license fails to submit proof of completion of continuing education requirements or pay the late fee within sixty (60) days after the expiration of the applicant's license, the license shall be deemed to have lapsed and the applicant shall be required to apply for reinstatement pursuant to § 512 of the Act (D.C. Official Code § 3-1205.12).

6706.11 The Board may, in its discretion, grant an extension of the sixty (60) day period to renew after expiration if the applicant's failure to submit proof of completion was for good cause. For purposes of this section, "good cause" includes the following:

(a) Serious and protracted illness of the applicant;

(b) The death or serious and protracted illness of a member of the applicant's immediate family.

6707 APPROVED CONTINUING EDUCATION PROGRAMS AND ACTIVITIES

Section 6707.2 is amended to read as follows:

6707.2 The Board may approve the following types of continuing education programs, if the program meets the requirements of § 6707.3:

(a) An undergraduate or graduate course given at an accredited college or university;

(b) A seminar or workshop;

(c) An education program given at a conference;

(d) In-service training;

(e) Home study courses; and

(f) Online courses.

Section 6707.3 is amended to read as follows:

6707.3 To qualify for approval by the Board, a continuing education program shall do the following:

(a) Be current in its subject matter;

(b) Be developed and taught by qualified individuals; and

(c) Meet one of the following requirements:

(1) Be administered or approved by a recognized national, state or local physical therapy organization; health care organization; accredited health care facility; or an accredited college or university; or

(2) Be submitted by the program sponsors or the applicant to the Board for review no less than sixty (60) days prior to the date of the presentation and be approved by the Board.

Section 6707.6 is amended to read as follows:

6707.6 The Board may approve the following continuing education activities by an applicant:

(a) Serving as an instructor or speaker at a conference, seminar, workshop, or in-service training;

(b) Publication of an article in a professional journal or publication of a book or a chapter in a book or publication of a book review in a professional journal or bulletin; and

(c) Participating in research as a principal investigator or research assistant.

6708 CONTINUING EDUCATION CREDITS

Section 6708.10 is amended to read as follows:

6708.10 The Board may grant an applicant who is the sole author or co-author of a published original paper, journal article or poster presentation, two (2) continuing education units or twenty (20) hours of continuing education credit, subject to the same restrictions set forth for books in § 6708.9.

A new section 6709 is added to read as follows:

6709 LICENSURE BY ENDORSEMENT

6709.1 The Board shall issue a license by endorsement to a physical therapist who has a valid unrestricted license in good standing from another jurisdiction of the United States and who meets all other requirements of this section.

6709.2 An applicant for licensure as a physical therapist by endorsement shall submit with a completed application the following:

(a) Official, certified proof of licensure as a physical therapist in good standing from another jurisdiction of the United States;

(b) Official, certified proof, from the body administering the examination, that the applicant has passed the Board-approved national licensure examination in physical therapy; and

(c) Proof pursuant to § 6702.1.

6709.3 After submission of the completed application and all required documentation, the Board may approve the applicant to take the District of Columbia licensure examination in physical therapy.

6709.4 An applicant shall take and pass the District of Columbia licensure examination in physical therapy after obtaining Board approval pursuant to § 6709.3.

A new section 6710 is added to read as follows:

6710 LAWFUL PRACTICE

6710.1 A physical therapist licensed under this act is fully authorized to practice physical therapy within the District of Columbia as defined herein.

6710.2 A physical therapist shall adhere to the recognized standards of ethics of the physical therapy profession and as further established by rule.

6710.3 A physical therapist may purchase, store and administer topical and aerosol medications as part of the practice of physical therapy as defined herein, as long as the purchasing, storage, and administration of those medications is carried out pursuant to all laws and regulations of the Federal Government and District of Columbia.

6710.4 A physical therapist shall use the letters "PT" in connection with the physical therapist's name or place of business to denote licensure under the Act.

6710.5 Unless authorized to practice physical therapy, a person or business entity, its employees, agents or representatives shall not use in connection with that person's name or the name or activity of the business, the words "physical therapy," "physical therapist," "physiotherapy," "physiotherapist," "registered physical therapist," the letters "PT," "DPT," "LPT," "RPT," or any other words, abbreviations or insignia indicating or implying directly or indirectly that physical therapy is provided or supplied.

6710.6 A person or business entity shall not advertise or otherwise promote another person as being a "physical therapist" or "physiotherapist" unless the individual so advertised or promoted is licensed as a physical therapist under the Act.

6710.7 A person or business entity that offers, provides or bills any other person for services shall not characterize those services as "physical therapy" or "physiotherapy" unless the individual performing those services is a person licensed as a physical therapist under the Act.

6710.8 A physical therapy assistant shall use the letters "PTA" in connection with his or her name.

6710.9 A physical therapist shall be responsible for managing all aspects of the physical therapy care of each patient. A physical therapist shall provide:

(a) The initial evaluation for each patient and all supporting documentation;

(b) Periodic reevaluation of each patient and all supporting documentation; and

(c) The documented discharge of the patient, including the response to therapeutic intervention at the time of discharge.

6710.10 A physical therapist shall assure the qualifications of all physical therapy students, physical therapy assistants, physical therapy aides, and first-time applicants practicing pursuant to § 6711, under his or her direction and supervision.

6710.11 A physical therapist may not have more than a total of three (3) physical therapy students or physical therapy aides or physical therapy assistants or first-time applicants for a physical therapy license practicing pursuant to § 6711, under his or her direct supervision at any one time.

6710.12 A physical therapist shall review and co-sign any documentation written by a physical therapy student, physical therapy assistant, physical therapy aide, or first-time applicant for a physical therapy license practicing pursuant to § 6711.

Section 6711 is amended to read as follows:

6711 PRACTICE OF PHYSICAL THERAPY BY STUDENTS OR GRADUATES

6711.1 This section shall apply to the following:

(a) Students enrolled in recognized schools or colleges as candidates for a degree in physical therapy; and

(b) Applicants for a license whose first application for a license in the District of Columbia is pending.

6711.2 A student or applicant may perform actions which require a license as a physical therapist only in accordance with the Act and this section.

6711.3 A first-time applicant for a physical therapy license may practice physical therapy under the direct supervision of a physical therapist licensed in the District of Columbia while the initial application is pending.

6711.4 A first-time applicant practicing physical therapy pursuant to § 6711.3 who fails the national examination or the District examination on the first attempt shall not thereafter continue to practice physical therapy until such time as a physical therapy license is duly issued to that individual.

6711.5 A student or applicant may practice physical therapy only under the direct supervision of a licensed physical therapist.

6711.6 A student or applicant shall identify himself or herself as a student or applicant at all times when performing actions of a physical therapist

6711.7 A physical therapist supervising a student or an applicant shall be fully responsible for all of the actions performed by the student or applicant during the time of the supervision and is subject to disciplinary action for any violation of the Act or this chapter by the person supervised.

6711.8 A student may not be paid or receive compensation of any nature, directly or indirectly from a patient.

6711.9 A student or applicant shall be subject to all of the applicable provisions of the Act and this chapter. The Board may deny an application for a license by, or take other disciplinary action against a student or applicant who is found to have violated the Act or this chapter, in accordance with chapter 41 of this title.

6711.10 If the Board finds that a student or applicant has violated the Act or this chapter, the Board may, in addition to any other disciplinary actions permitted by the Act, revoke, suspend, or restrict the privilege of the student or applicant to practice.

6711.11 Pursuant to § 6710.12, a physical therapist shall review and co-sign any documentation written by a physical therapy student or a first-time applicant for a physical therapy license practicing pursuant to § 6711.

The section heading for 6712 is amended to read as follows:

6712 PHYSICAL THERAPY ASSISTANTS AND AIDES

Section 6712.1 is amended to read as follows:

6712.1 A physical therapy assistant or physical therapy aide may perform physical therapy functions only in accordance with this section.

Section 6712.3 is amended to read as follows:

6712.3 A physical therapy aide may perform the following functions under the direct supervision of a physical therapist:

(a) Gait practice;

(b) Activities of daily living;

(c) Transfer activities;

(d) Hot or cold packs;

(e) Paraffin bath;

(f) Hydrotherapy;

(g) Whirlpool; and

(h) Therapeutic exercises.

Section 6712.5 is amended to read as follows:

6712.5 Pursuant to § 6710.12, a physical therapist shall review and co-sign any documentation written by a physical therapist's assistant or physical therapist's aide.

Section 6712.6 is deleted.

The section heading for 6713 is amended to read as follows:

6713 RESTRICTED LICENSES

Section 6713.1 is amended to read as follows:

6713.1 Pursuant to § 514 of the Act (D.C. Official Code § 3-1205.14) the Board may restrict the license of any person as a condition of probation pursuant to § 514(c)(7) of the Act (D.C. Official Code § 3-1205.14(c)(7)).

6714 STANDARDS OF CONDUCT

Section 6714.4 is amended to read as follows:

6714.4 Any holder of a license under this chapter or any person authorized to practice physical therapy or to perform physical therapy functions under this chapter shall comply with the standards of ethical and professional conduct established by the Federation of State Boards of Physical Therapy, as they may be amended or republished from time to time.

A new section 6715 is added to read as follows:

6715 SCOPE OF PRACTICE

6715.1 A physical therapist or any person so authorized under the Act to perform physical therapy may perform the following functions:

(a) Examining individuals with impairments, functional limitations and disabilities or other health-related conditions in order to determine a diagnosis, prognosis and course of intervention while utilizing tests and measurements which may include the following:

(1) Aerobic capacity or endurance;

(2) Anthropometric characteristics;

(3) Arousal, attention, and cognition;

(4) Assistive and adaptive devices;

(5) Arterial, venous and lymphatic circulation;

(6) Cranial and peripheral nerve integrity;

(7) Environmental, home and work barriers;

(8) Ergonomics and body mechanics;

(9) Gait, locomotion, and balance;

(10) Integumentary integrity;

(11) Joint integrity and mobility;

(12) Motor control and motor learning;

(13) Muscular strength, power and endurance performance;

(14) Neuromotor development and sensory integration;

(15) Pain;

(16) Posture;

(17) Prosthetic and orthotic requirements;

(18) Range of motion, including muscle length;

(19) Reflex integrity;

(20) Self-care and home management, including activities of daily living;

(21) Sensory integrity;

(22) Ventilation and respiration or gas exchange; and

(23) Work, community, leisure integration or reintegration including instrumental activities of daily living.

(b) Alleviating impairment and functional limitation by designing, implementing, and modifying therapeutic interventions that include, but are not limited to:

(1) Coordination, communication and documentation;

(2) Patient or client-related instruction;

(3) Therapeutic exercise;

(4) Functional training in self-care and home management, including activities of daily living and instrumental activities of daily living;

(5) Functional training in community and job, school or play integration or reintegration activities including instrumental activities of daily living, work hardening, and work conditioning;

(6) Manual therapy techniques, including mobilization or manipulation;

(7) Prescription, application and, as appropriate, fabrication of devices and equipment which are assistive, adaptive, orthotic, protective, supportive and prosthetic;

(8) Airway clearance techniques;

(9) Integumentary repair and protection techniques;

(10) Electrotherapeutic modalities; and

(11) Physical agents and mechanical modalities.

(c) Preventing injury, impairment, functional limitation and disability, including the promotion and maintenance of health, wellness, fitness and quality of life in all age populations.

(d) Engaging in consultation, education and research.

6799 DEFINITIONS

Section 6799 is amended to read as follows:

6799.1 As used in this chapter, the following terms shall have the meanings ascribed:

Applicant - a person applying for a license to practice physical therapy under this chapter.

Board - the Board of Physical Therapy, established by § 209 of the Act (D.C. Official Code § 2-1202.09).

Continuing education unit – a unit of measurement representing ten (10) hours of continuing education credit.

Direct supervision - the supervision in which a physical therapist is available on the premises and within vocal communication either directly or by a communications device.

Physical therapist - a person licensed to practice physical therapy under the Act.

Physical therapy aide - a person trained by a physical therapist to perform designated routine tasks related to the operation of a physical therapy service under the direct supervision of a physical therapist.

Physical therapy assistant - a graduate of a physical therapy assistant program accredited by an agency recognized by the Secretary of the Department of Education or the Council of Postsecondary Accreditation who performs selected physical therapy procedures and related tasks under the direct supervision of a physical therapist.

Practice of physical therapy – the independent evaluation of human disability, injury, or disease by means of noninvasive tests of neuromuscular functions and other standard procedures of physical therapy, and the treatment of human disability, injury, or disease by therapeutic procedures, rendered on the prescription of or referral by a licensed physician, osteopath, dentist, or podiatrist, or by a licensed registered nurse certified to practice as an advanced registered nurse as authorized pursuant to § 601 of the Act (D.C. Official Code § 3-1206.01), embracing the specific scientific application of physical measures to secure the functional rehabilitation of the human body. These measures include the use of therapeutic exercise, therapeutic massage, heat or cold, air, light, water, electricity, or sound for the purpose of correcting or alleviating any physical or mental disability, or preventing the development of any physical or mental disability, or the performance of noninvasive tests of neuromuscular functions as an aid to the detection or treatment of any human condition.

Restricted license – a license upon which the board has placed any restrictions.

6799.2 The definitions in § 4099 of chapter 40 of this title are incorporated by reference into and are applicable to this chapter.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments in writing not later than thirty (30) days after the date of publication of this notice in the D.C. Register. Comments should be sent to the Department of Health, Office of the General Counsel, 825 North Capitol Street, N.E., 4th Floor, Washington, D.C. 20002. Copies of the proposed rules may be obtained from the Department at the same address during the hours of 9:00 a.m. to 5:00 p.m., Monday through Friday excluding holidays.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the intent to adopt an amendment to section 905 of Title 29 of the District of Columbia Municipal Regulations (DCMR) entitled "Medicaid Reimbursement to Out-of-State Skilled Nursing and Immediate Care Facilities". The proposed rules would amend the existing rules by requiring authorization by the Medicaid Program prior to admission of Medicaid patients in out-of-state nursing homes.

A recent survey revealed a significant number of vacant nursing beds located in the District of Columbia. The proposed rules ensure placement of Medicaid patients in nursing facilities located in the District of Columbia when services are available and clinically appropriate.

The Director also gives notice of intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 905 (Medicaid Reimbursement to Out-of-State Skilled Nursing and Intermediate Care Facilities) of Title 29 Public Welfare (May 1987) of the District of Columbia Municipal Regulations is amended by designating the existing subsection 905.3 as 905.5 and adding two new subsections to read as follows:

905.3 The Department of Health, Medical Assistance Administration (MAA) shall not reimburse a nursing home located outside of the District of Columbia when an appropriate clinical placement is available in the District.

905.4 Each out-of-state nursing home shall obtain written authorization from MAA prior to admission of D.C. Medicaid patients. Each request for authorization shall be submitted to the Public Health Analyst for Nursing Facilities, MAA, Office of Disabilities and Aging, 825 North Capitol Street, NE, 4th Floor, Washington, DC 20002.

Comments on the proposed rules should be sent in writing to Robert Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, not later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH

NOTICE OF PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the intent to adopt an amendment to Chapter 50 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Medicaid Reimbursement for Personal Care Services". The proposed amendment clarifies that the total number of hours per day personal care services are available for reimbursement shall not exceed eight hours.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Amend Section 5009 (Reimbursement) of Title 29 DCMR by deleting subsection 5009.2 in its entirety and replacing it to read as follows:

5009.2 Reimbursement for personal care services shall not exceed eight (8) hours of service per day per patient. Reimbursement for services shall not exceed one thousand and forty hours (1040) hours in any twelve (12) month period, unless prior authorization is obtained from MAA.

Comments on the proposed rules should be sent to Robert Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, not later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

Office of Tax and Revenue

NOTICE OF PROPOSED RULEMAKING

The Office of Tax and Revenue (OTR), pursuant to the authority set forth in the D.C. Official Code § 1-204.24c, as amended by Section 155 of the District of Columbia Appropriations Act 2001, approved November 22, 2000 (114 Stat 2476; Pub. L. 106-522) and the Office of the Chief Financial Officer, Financial Management and Control Order No. 00-5, effective June 7, 2000, hereby gives notice of his intent to adopt new Taxation Regulations. The proposed regulations will add a new Section 109 to Chapter 1 of Title 9 of the D.C. Municipal Regulations (DCMR).

The proposed regulations will delete present Section 109 of Chapter 1 of Title 9, District of Columbia Municipal Regulations Section 109.1 through 109.5, substituting therefor Sections 109.1 through 109.99

The following new Section 109, **CONSOLIDATED RETURNS TAX REGULATIONS**, is added to Chapter 1 of Title 9 DCMR:

109 CONSOLIDATED TAX RETURNS

109.1 District of Columbia affiliated group means an "affiliated group" as defined in §1504 of the Internal Revenue Code of 1986, as amended (IRC). Generally, District of Columbia affiliated groups shall not include any corporation that does not have gross income derived from sources within the District and nexus to the District of Columbia. Members of an affiliated group that are exempt from District taxation cannot be included in the consolidated return.

(a) District of Columbia affiliated group may not include any corporation, which is a Qualified High Technology Company as defined in D.C. Official Code § 47-1817.01(5)(A) (a QHTC) and those corporations, described in IRC § 1504(b). A QHTC may opt out of status under D.C. Official Code §47-1817.01(5)(A) and be eligible to be included in a District of Columbia affiliated group. See §109.40.

(b) If a Qualified High Technology Company that has not made an election under §109.40 ceases to be a Qualified High Technology Company, such corporation (and any successor of such corporation) may not be certified as a Qualified High Technology Company before the 61st month beginning after its first taxable year in which it ceased to be a Qualified High Technology Company. During this period, such corporation is not eligible to make an election under §109.40.

(c) Each member of a District of Columbia affiliated group shall be jointly and severally liable for the taxes, interest and penalties of the District of Columbia affiliated group. If a corporation is a member of the District of Columbia affiliated group for a part of the year, then the corporation shall be liable for the tax liability attributed to that portion of the year that the corporation was a member of the District of Columbia affiliated group.

(d) The "gross income derived from sources within the District" requirement in D.C. Official Code §47-1805.02(5)(D) is waived for a corporation that meets the following requirements:

(1) A member of a regulated industry whose revenue is determined by means of a rate-setting procedure by a federal government agency, but only where the regulatory requirements to which the industry is subject impose restrictions on the structure of the affiliated group,

(2) A member of an affiliated group as defined in §1502 of the IRC, and

(3) In a trade or business in the District.

109.2 All members of a District of Columbia affiliated group must use the same accounting method and the same accounting period.

(a) Unless otherwise provided by these rules or inconsistent with the provisions of the D.C. Official Code, the consolidated taxable income for a District of Columbia consolidated return year shall be determined in the same manner and under the same procedures, including intercompany adjustments and eliminations, as are required by the federal consolidated return regulations.

(b) All intercompany transactions between and among members of a District of Columbia affiliated group will be eliminated in determining the District of Columbia apportionment factors.

(c) An intercompany transaction is a transaction between corporations that are members of the same District of Columbia affiliated group immediately before and after the transaction.

(d) Any deferred gain, loss or deduction from a prior transaction with a member of a District of Columbia affiliated group shall be recognized for District of Columbia purposes when the member subsequently ceases to be a member of that District of Columbia affiliated group or when the asset involved is transferred to a corporation which is not a member of District of Columbia affiliated group.

(e) All supplementary and supporting schedules filed with a District of Columbia consolidated return shall be prepared in columnar form. One column being provided for each corporation included in the consolidated return, with the parent corporation information reported in the first column. Supporting schedules for the consolidated return shall also include a column for totals of like items before adjustments are made, a column for intercompany eliminations and adjustments, and a column for totals of like items after giving effect to the eliminations and adjustments.

109.3 Each member of a District of Columbia affiliated group must have gross income in any amount derived from sources within the District of Columbia.

(a) In the case of a corporation that is a member of the District of Columbia affiliated group for a part of the taxable year, the District of Columbia consolidated return shall include the income of the corporation for only that part of the year that it is a member of the District of Columbia affiliated group. If the new member is an existing D.C. corporation and not a member of another District of Columbia affiliated group, a final short-year separate year return must be filed for the period prior to becoming a member of the affiliated group. If the new member was a member of another District of Columbia affiliated group, its taxable income or loss for the period prior to joining the new District of Columbia affiliated group must be included in the consolidated taxable income of its prior District of Columbia affiliated group. Correspondingly, if a member leaves a District of Columbia affiliated group, its taxable income or loss for the remainder of the taxable year shall be reported on a separate short-year tax return or included in the consolidated tax return of its new District of Columbia affiliated group, where permissible under these rules.

(b) District Taxable Income is computed as if a consolidated federal corporate income tax return was filed that included all Affiliates.

(c) The following are computed on a consolidated basis as if all Affiliates were a single corporation filing a District corporate income tax return:

(1) District adjustments and allocation of business income;

(2) Apportionment: Intergroup Transactions are eliminated when computing apportionment factors (See 9 DCMR §§ 109.20);

(3) Net Operating Loss;

(4) District Taxable Income is computed on a consolidated ~~basis~~;

(5) District Franchise Tax;

(6) District Tax Credits; and

(7) Election and Revocation in accordance with 9 DCMR §§ 109.4 and 109.6.

109.4 In order to file a District of Columbia consolidated return; the members of a District of Columbia affiliated group must be part of the affiliated group that files a federal consolidated return pursuant to §1501 of the IRC.

(a) If a group wishes to exercise its privilege of filing a consolidated return, such consolidated return must be filed not later than the last day prescribed by law (including extensions of time) for the filing of the common parent's return. Such consolidated return may not be withdrawn after such last day.

(b) The election made by the common parent is effective prospectively and only if accompanied by a written consent to the election signed by each member of the District of Columbia affiliated group. The completed written consent of all members shall be attached to the District of Columbia consolidated return for the taxable year for which the election is made.

(c) Election to file a consolidated return is binding to the District of Columbia affiliated group for the first year of election and for subsequent years as long as the District of Columbia affiliated group remains in existence, unless a written request for revocation is submitted to the Office of Tax and Revenue and the Office of Tax and Revenue grants permission to a group to discontinue filing consolidated returns.

(d) The making of a District consolidated return shall be upon the condition that all corporations which at any time during the taxable year have been members of the affiliated group consent to all the consolidated return regulations prescribed under Title 9 of the District of Columbia Municipal Regulations prior to the last day prescribed by law for the filing of such return. The making of a District consolidated return shall be considered as such consent.

(e) If an eligible corporation becomes a member of the District of Columbia affiliated group after the beginning of the District of Columbia consolidated return year or ceases to be a member of the District of Columbia affiliated group during the consolidated return year, two tax returns will be due for that taxable year. The District of Columbia consolidated return shall include amounts attributable to such corporation for the part of the year in which it was a member of the District of Columbia affiliated group. A separate return shall be filed and include the amounts attributable to such corporation for the short taxable year when it was not a member of the District of Columbia affiliated group.

109.5 In taxable years after the election, any corporation deriving gross income, in any amount, from District of Columbia sources that was not a member of the original federal affiliated group in the year of the election but is a member of the federal affiliated group in the current year shall be required to join the District of Columbia affiliated group.

(a) The new corporation shall be deemed to have waived any objection to the filing of the District of Columbia consolidated return by its consent, if any, to join in filing a District of Columbia consolidated return by the common parent of the District of Columbia affiliated group.

(b) The new member joining the District of Columbia affiliated group shall be required to consent to the election to file a District of Columbia Consolidated Corporation Franchise Tax Return. A written consent shall be attached to the District of Columbia consolidated return for the first taxable year in which the new member joins the District of Columbia affiliated group.

109.6 The election shall terminate automatically upon the revocation or termination of the federal consolidated election, and the common parent shall notify the Office of Tax and Revenue within thirty (30) days regarding the revocation or termination of the federal consolidated election.

(a) If the District of Columbia affiliated group wants to revoke the election in a subsequent tax year, the group must request in writing and receive written permission from the Office of Tax and Revenue. The request to discontinue filing a D.C. consolidated return must be made at least ninety (90) days before the due date (including any extension of time for filing) of the return.

(b) If the request for revocation or termination of District of Columbia consolidated election is denied by the Office of Tax and Revenue, the District of Columbia affiliated group may file a written protest and request a hearing within thirty (30) days from the denial date.

(c) If a corporation has ceased to be a member of District of Columbia affiliated group and if such cessation resulted from a bona fide sale or exchange of its stock for fair value and occurred prior to the date upon which any deficiency is assessed, the Office of Tax and Revenue may make an assessment and collect the deficiency from the former member.

109.7 If the District of Columbia affiliated group files a consolidated return for the first year of filing, it must make payment of estimated tax on a consolidated basis for subsequent years. The District of Columbia affiliated group is treated as a single corporation for purposes of D.C. Official Code 47-1812.14(a) (relating to payment of estimated tax by corporations) and D.C. Official Code 47-1812.14(b) (relating to underpayment of estimated tax by corporations).

(a) If separate returns are filed by the members of the District of Columbia affiliated group for the taxable year after receiving consent for discontinuance from Office of Tax and Revenue, the amount of any estimated tax payments with respect to a consolidated payment of estimated tax for such year will be credited against the separate tax liabilities of the members in any manner designated by the common parent which is reasonably satisfactory to the Office of Tax and Revenue. For example, the manner of allocation will be satisfactory to the Office of Tax and Revenue if it does not jeopardize the collection of the corporation franchise tax liability from such members.

(b) Supporting schedules shall be filed with the District of Columbia consolidated tax return for each member. The statement of gross income and deductions and other schedules required for each corporation shall be prepared and filed in columnar form so that the details of the items of gross income, deductions, and credits for each member may be readily ascertained. A column shall also be provided giving effect to any eliminations and adjustments. The items included in the column for eliminations and adjustments should be symbolized to identify contra items affected, and suitable explanations appended, if necessary. Similar schedules shall contain a columnar form of reconciliation of retained earnings for each corporation, together with a reconciliation of consolidated retained earnings. Consolidated balance sheets at the beginning and close of the taxable year of the group shall accompany the consolidated return prepared in a form similar to that required for other schedules. Transactions with a subsidiary which is not included as part of the District consolidated return shall not be considered as intercompany transactions for elimination purposes in computing the consolidated District taxable income for the return period.

109.8 Federal Taxable Income is computed as if a consolidated federal corporate income tax return was filed that included all Affiliates. Federal Treasury regulations under 26 Code of Federal Regulations §1.1502 *et seq.* and interpretations thereof regarding intercompany transactions apply in determining the federal taxable income of a District consolidated group.

109.9 ALLOCABLE INCOME [Reserved]

109.10 The following adjustments may be made under these regulations:

(a) Nothing herein shall prevent the exercise of authority under D.C. Official Code § 47-1810.03 to distribute, apportion, or allocate income or deductions between or among corporations where such action is necessary in order to prevent evasion of taxes or clearly to reflect the income of any such corporation. OTR also has the authority to determine whether such method should be followed on a consistent basis, from year to year.

(b) The District may require that a consolidated return be filed ~~under~~ D.C. Official Code § 47-1805.02(D)(5)(C)(iv) for an affiliated group that is eligible but where an election to file a consolidated return has not been filed if the District determines that a consolidated return is necessary to prevent evasion of taxes or to clearly reflect the taxable income that is attributable to the business conducted in the District by the affiliated group.

109.11-
109.19 [Reserved.]

109.20 The three-factor apportionment requirements of D.C. Official Code §47-1810.02(d) shall be taken into account by an affiliated group doing business within and without the District of Columbia. All members of an affiliated group which join in the filing of a District consolidated tax return shall be considered as one "person" to determine the portion of the consolidated net income earned within and without the District by the same method prescribed in the statute cited above. All intercompany transactions shall be eliminated in the determination of the apportionment factors.

(a) A single consolidated apportionment factor is constructed for the affiliated group. The property, payroll, and sales factors include the property, payroll, and sales for all members of the consolidated group. The consolidated apportionment factor constructed is then multiplied by the consolidated adjusted federal income to determine the adjusted federal income apportioned to the District of Columbia.

(b) The members of the affiliated group may not determine separate apportionment factors to apply to their portion of the consolidated adjusted federal income.

(c) The District property factor for the consolidated group shall be determined pursuant to D.C. Official Code §47-1810.02(e) and 9 DCMR §§ 125 and 126.

(d) The District payroll factor for the consolidated group shall be determined pursuant to D.C. Official Code §47-1810.02(f) and 9 DCMR §§125 and 127.

(e) The District sales factor for the consolidated group shall be determined pursuant to D.C. Official Code §47-1810.02(g) and 9 DCMR §§ 125 and 128.

(f) Where all members of the consolidated group are subject to a special apportionment formula provided by D.C. Official Code §47-1810.02(h), ~~and~~ approved by the Office of Tax and Revenue, the consolidated group will determine a single consolidated apportionment factor using the special formula. Where all members of the affiliated group are not subject to the identical special formula approved by the Office of Tax and Revenue, the special formula is not available to the affiliated group.

(g) Under D.C. Official Code §47-1810.02(h), the following alternative methods may be requested or prescribed in respect to all or a part of taxpayer's business activity where necessary to fairly represent the extent of taxpayer's business activity in the District:

(1) Separate accounting;

(2) The exclusion of any one or more of the factors;

(3) The inclusion of one or more additional factors that will fairly represent the taxpayer's business activity in the District; or

(4) The employment of any other method to effectuate an equitable allocation and apportionment of the taxpayer's income.

(h) Apportionment factors are subject to the adjustments set out in §109.10, if necessary to clearly reflect income or to prevent the evasion of tax.

109.21-
109.29 [Reserved]

109.30 In computing the net income of the consolidated group, there shall be allowed a deduction for the consolidated net operating loss, in the same manner as allowed under IRC §§ 172 and 1502 and the federal income tax regulations thereunder and D.C. Official Code Section 47-1803.03(a)(14).

(a) Since an affiliated group filing a District consolidated return often does not include all the members included in the federal return, the net operating loss deduction is limited to the amount of deduction that would otherwise be allowed for federal income tax purposes had the federal return been filed including only the District of Columbia entities for the tax year involved. The federal consolidated return must be adjusted to reflect only District-source losses.

(b) Each member of a District of Columbia affiliated group ~~shall have~~ its own net operating loss deduction (before apportionment) for loss years prior to 2000 and D.C. apportioned net operating loss deduction (after apportionment) for loss years 2000 and thereafter where:

(1) such member filed a separate District of Columbia franchise tax return for years 2000 and thereafter, or
(2) such member was included in a different District of Columbia affiliated group for years 2001 and thereafter.

(c) The following is an example of the application of § 109.30(b):

Corporation A files a return on separate company basis for tax year 2000 and has a D.C.-apportioned net operating loss of $50,000 to be carried forward to subsequent years. For taxable year 2001, Corporation A joins with Corporation

B to file a consolidated return. Corporation A utilizes only $30,000 of its $50,000 D.C.-apportioned net operating loss from taxable year 2000 to the extent of its total taxable income of $30,000 for taxable year 2001.

Tax Year 2001	Corporation A	Corporation B	Consolidated Income
Total taxable income before apportioned NOL deduction	$30,000	$80,000	$110,000
Less apportioned NOL deduction	(30,000)		(30,000)
Total taxable income			$ 80,000
Carryover to 2002	($20,000)		

(d) If the District of Columbia affiliated group has a consolidated net operating loss carry forward from prior taxable years, the consolidated net operating loss of that District of Columbia affiliated group shall be carried forward and utilized by such District of Columbia affiliated group to the extent that such District of Columbia affiliated group has apportioned District of Columbia taxable income in future years.

(e) The following is an example of the application of § 109.30(d):

Tax Year 2001	Corporation M	Corporation N	Consolidated Income
Total taxable income before apportioned NOL deduction	$30,000	($80,000)	($ 50,000)

Tax Year 2002	Corporation M	Corporation N	Consolidated Income
Total taxable income before apportioned NOL deduction	$50,000	($20,000)	$ 30,000
Less apportioned NOL deduction			(30,000)
Total taxable income			$ -0-
Consolidated net operating loss carry forward to 2003 and beyond			($20,000)

(f) The Separate Return Limitation Year (SRLY) provisions of IRC §172 and IRC §1502, and the federal income tax regulations thereunder, shall apply in those cases where a member of a District of Columbia affiliated group which has a D.C.-apportioned net operating loss carryforward leaves the group and either files a separate District of Columbia franchise tax return or joins in the filing of a consolidated return with a different District of Columbia affiliated group. The prorated amount assigned to each member who incurred the loss is determined by the following formula:

(A/B) x C = D
A/B = Ratio based on one corporation's loss to total corporation losses
C = Consolidated net operating loss
D = Prorated amount of consolidated net operating loss assigned to the member.

(g) The following is an example of the application of § 109.30(f):

In 2001 Corporations B and C were members of a District of Columbia affiliated group which had Corporation A as the common parent. On January 1, 2002 Corporation B and Corporation C became members of a different District of Columbia affiliated group the common parent of which was Corporation D.

The ABC consolidated group had a consolidated loss of $20,000 for tax year 2001.

Tax Year 2001	Corporation A	Corporation B	Corporation C	Consolidated Income
Taxable Income	$100,000	$(80,000)	$(40,000)	$(20,000)

Calculation of Corporation B's share of Tax Year 2001 Consolidated Loss:

A = $(80,000) for Corporation B
B = $(120,000) for Corporation B and Corporation C
C = $(20,000) for consolidated loss

($80,000/$120,000) x $20,000 = $13,333 loss assigned to Corporation B

Calculation of Corporation C's share of Tax Year 2001 Consolidated Loss:

A = $(40,000) for Corporation B
B = $(120,000) for Corporation B and Corporation C
C = $(20,000) for consolidated loss

($40,000/$120,000) x $20,000 = $6,667 loss assigned to Corporation C.

For taxable year 2002, Corporation D, Corporation B and Corporation C have taxable income before NOL deduction of $80,000, $60,000, and $4,500, respectively. In this situation, Corporation B will utilize all of its $13,333 of D.C.-apportioned net operating loss carryforward from 2001, but Corporation C will utilize only $4,500 of its $6,667 D.C.-apportioned net operating loss carryforward from 2001 to the extent of its 2002 taxable income of $4,500.

The DBC consolidated group has a consolidated loss of $17,833 for the tax year 2002.

Tax Year 2002	Corporation D	Corporation B	Corporation C	Consolidated Income
Taxable Income before apportioned NOL deduction	$80,000	$60,000	$4,500	$144,500
Less apportioned NOL deduction		(13,333)	(4,500)	(17,833)
Total taxable income				$126,667
Carryover to 2003			($2,167)	

(h) A surviving corporation in a merger is permitted to use District of Columbia net operating losses and District of Columbia apportioned net operating losses of a merged corporation, provided that the surviving corporation for federal tax purposes is permitted to use the federal net operating losses, if any, of the merged corporation. IRC §§ 381 and 382 apply with respect to the allowable loss.

109.31-
109.39 [Reserved.]

109.40 Special "Opt-Out" Rule for Qualified High Technology Company (QHTC): A corporation that qualifies under D.C. Official Code § 47-1817.01.(5)(A) as a QHTC may elect to join in the filing of a consolidated tax return with its affiliated group. By electing to join in the filing of a consolidated return, the corporation that would otherwise qualify as a QHTC shall be deemed to opt-out of QHTC status on a permanent basis. Such corporation and its affiliated group shall, by joining in the filing of a consolidated return, be permanently estopped from qualifying for tax benefits under D.C. Official Code §47-1817.

109.41-
109.99 [Reserved.]

All persons interested in commenting on the subject matter in this proposed rulemaking may file comments in writing, not later than thirty (30) days after the publication of this notice in the D.C. Register, with the Office of Tax and Revenue, c/o Office of the General Counsel, 941 North Capitol Street, N.E., Suite 810, Washington, DC 20002

ZONING COMMISSION FOR THE DISTRICT OF COLUMBIA
NOTICE OF PROPOSED RULEMAKING
Case No. 02-22
(Map Amendment – Square 754, Lots 103 to 106 and 109
East side of 2nd Street N.E. between F and E Streets)

The Zoning Commission for the District of Columbia, pursuant to its authority under § 1 of the Zoning Act of 1938, approved June 20, 1938 (52 Stat. 797, as amended; D.C. Official Code § 6-641.01 (2001 ed.)), hereby gives notice of its intent to amend the Zoning Map of the District of Columbia.

The purpose of this rezoning is to adopt a zoning designation for the subject property that is not inconsistent with the Comprehensive Plan Amendments Act of 1994. The proposed map amendment applies to property on the east side of 2nd Street N.E. between F and E Streets (Square 754, Lots 103 to 106, and 109).

Final rulemaking action shall be taken in not less that thirty (30) days after the date of publication of this notice in the *D.C. Register*.

The following rulemaking action is proposed:

Amend the Zoning Map of the District of Columbia to rezone Square 754, Lots 103 to 106, and 109 from CAP/R-4 to CAP/C-2-A.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, to Alberto P. Bastida, Office of Zoning, 441 4th Street, N.W., Washington D.C. 20001. Comments must be received not later than thirty (30) days after the publication of this notice in the *D.C. Register*. A copy of this proposal may be obtained, at cost, by writing to the above address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in sections 2(b) and 5 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983 (the "Act") effective February 24, 1984 (D.C. Law 5-48, D.C. Official Code § 44-501 (b) and 44-504), and Mayor's Order 98-137, dated August 20, 1998, hereby gives notice of the adoption on an emergency basis of the following amendment to Chapter 27 of Title 22 of the District of Columbia Municipal Regulations (DCMR). The emergency and proposed rules amend Chapter 27 to change the standard of care in, and qualifications for certification of, Level I and Level II Adult Trauma Facilities.

This emergency action is necessary to enable the District's adult trauma centers to satisfy the requirements of the American College of Surgeons (ACS) when it conducts its re-certification inspections of the District's three Level I trauma facilities beginning on April 21, 2004. If the District fails to have amendments in place thirty (30) days before the inspections begin, the ACS will not be able to certify any of the District's Level I adult trauma facilities. The emergency rules were adopted on March 22, 2004, and became effective immediately on that date. The emergency rules will expire on July 20, 2004, or upon publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever occurs first.

The Director also gives notice of his intent to take final rulemaking action to adopt this amendment in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Pursuant to section 5(j) of the Act, the proposed rules are being transmitted to the Council of the District of Columbia, and the final rules will not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first, and publication of a notice of final rulemaking in the *D.C. Register*.

Chapter 27 (Adult Trauma Care) of Title 22 (Public Health and Medicine) (August 1986) of the District of Columbia Municipal Regulations is amended as follows:

I. Section 2700 is amended as follows:

A. Amend subsection 2700.3 to read as follows:

2700.3 An inclusive trauma care system is a system that is fully integrated into the EMS and is designed to meet the needs of all injured patients requiring care in an acute care facility, regardless of severity of injury, geographic location, or population density.

B. Amend paragraph 2700.4(k) by striking the phrase "Medical evaluation." and inserting the phrase "Research." in its place.

C. Amend subsection 2700.10 to read as follows:

2700.10 For optimal care of the severely injured, Level I and Level II facilities shall meet the following requirements:

(a) Skilled surgeons and other members of the trauma team shall be immediately available;

(b) When an arriving patient meets the hospital-specific guidelines defining a major resuscitation, the attending surgeon shall be present in the emergency department:

(1) Upon arrival of the patient, when there is advance notification from the field; or

(2) Within fifteen (15) minutes of activating the trauma team, when there is no advance notification;

(c) Compliance with the requirements of subsections (a) and (b) at a rate of eighty percent (80%) or greater shall be documented; and

(d) The following minimum criteria shall be used to define a major resuscitation:

(1) Confirmed blood pressure less than ninety (90) millimeters of mercury (mmHg) at any time in adults;

(2) Respiratory compromise, airway obstruction, or intubation;

(3) Transfer patients from other hospitals receiving blood to maintain vital signs;

(4) Gunshot wounds to the abdomen, neck, or chest;

(5) Glasgow Coma Scale (GCS) less than eight (<8) with mechanism attributed to trauma; and

(6) Emergency physician's discretion.

II. Subsection 2702.21 is amended to read as follows:

2702.21 Each surgeon member of the trauma team shall participate in a minimum of sixteen (16) hours of trauma related Continuing Medical Education (CME) courses per year. At least fifty percent (50%) of this CME shall be extramural, and both Category I and II CME may be counted toward satisfying this requirement.

III. Subsection 2703.2(f) is amended to read as follows:

(f) Assisting in maintaining a trauma registry, performing data collection, coding, including external causes of injury, e-coding and scoring, and developing processes for validation of data and submitting the data to the citywide trauma registry maintained by the District of Columbia Department of Health; and

IV. Section 2704 is amended as follows:

A. Amend subsection 2704.9 to read as follows:

2704.9 The minimum qualifications of an orthopedic surgeon on-call shall include board certification or eligibility for board certification during the first five (5) years after residency, documentation of a minimum of sixteen (16) hours of Category I or II CME per year in skeletal traumatology, and participation in the facility's trauma service educational and quality improvement activities.

B. Amend paragraph 2704.13(a) to read as follows:

(a) A complete stock of plaster, fiberglass cast, and splint material with adequate padding;

C. Amend subsection 2704.16 to read as follows:

2704.16 In each adult trauma care facility, a general orthopedist shall provide primary care for musculoskeletal injuries. When orthopedic trauma specialists are not immediately available, the initial orthopedic care may be provided by another member of the staff, who shall then transfer that patient to the specialist. Interhospital transfer shall be required in appropriate cases.

V. Subsections 2705.1 through 2705.7 are amended to read as follows:

2705.1 Each adult trauma care facility shall have the following specialties available in-house twenty-four (24) hours per day;

(a) General Surgery;

(b) Emergency Medicine; and

(c) Anesthesiology.

2705.2 The patient evaluation and treatment team shall consist of a team of surgeons that will include, at a minimum, a post-graduate resident in at least the fourth (4th) year of training.

2705.3 The attending surgeon shall participate in each major therapeutic decision and be present at each operative procedure. The hospital's trauma performance improvement program shall monitor compliance with the requirements of this section.

2705.4 An attending neurosurgeon shall be available and dedicated to that hospital's trauma service. This requirement may be satisfied by an in-house neurosurgery resident or physician who has special competence, as judged by the chief of neurosurgery, in the care of patients with neurological trauma, and who is capable of initiating measures directed toward stabilizing the patient and initiating diagnostic procedures.

2705.6 In Level I facilities, the requirement to provide anesthesiology services may be satisfied by anesthesiology chief residents or a certified nurse anesthetist (CRNA) capable of assessing emergency situations in trauma patients and providing any indicated treatment, including surgical anesthesia. Whenever a Level I facility uses an anesthesiology resident or a certified nurse anesthetist (CRNA) to satisfy this requirement, the facility shall notify the staff anesthesiologist on-call, who shall be promptly available.

2705.7 In Level II facilities, the requirement to provide anesthesiology services is satisfied when the staff anesthesiologist is in the hospital at the time of, or shortly after, the patient's arrival. Before the staff anesthesiologist arrives, an anesthesiology chief resident or certified nurse anesthetist (CRNA) capable of assessing emergency situations in trauma patients and of initiating and providing any indicated treatment shall be available.

VI. Sections 2706, 2707, and 2708 are amended to read as follows:

2706 FACILITY RESOURCES AND CAPABILITIES

2706.1 Emergency department personnel in each adult trauma care facility shall consist of at least the following:

(a) A designated physician director of the emergency department;

(b) Physicians with special competence in the care of the critically injured, who are designated members of the trauma team and are physically present in the emergency department and sufficient in number to provide coverage twenty-four (24) hours per day; and

(c) Nursing personnel with special capability in trauma care who provide continual monitoring of the trauma patient from hospital arrival to disposition in the Intensive Care Unit (ICU), Operating Room (OR), or patient care unit.

2706.2 The requirement for an emergency medicine physician may be satisfied by emergency medicine senior residents capable of assessing emergency situations in trauma patients and providing any indicated treatment. When senior residents are used to satisfy this requirement, the facility shall advise the staff specialist on-call who shall be promptly available. Institutions that have emergency medicine residency training programs shall provide supervision twenty-four (24) hours per day by an in-house attending emergency physician.

2706.3 A facility shall have a team available for twenty-four (24) hours per day in-house coverage in the emergency department. The team shall provide the initial management of the major trauma patient and shall consist of at least the following personnel:

(a) An emergency department attending physician with knowledge of trauma care who is Advanced Trauma Life Support (ATLS) Certified or has demonstrated an appropriate level of expertise as determined by the Trauma Service Director, but not less than sixteen (16) hours trauma-related CME, clinical involvement, and special interest in trauma;

(b) Surgical residents who shall be in at least the fourth (4th) year of post-graduate specialty training;

(c) An anesthesiologist; however, the initial response may be by a anesthesiology chief resident or a critical care nurse anesthetist with trauma proficiency, and the attending anesthesiologist shall be promptly available;

(d) A minimum of two (2) nurses familiar with emergency and critical care, qualified to function as members of the trauma team by specific criteria defining orientation and practice requirements; at least one (1) nurse shall have specialized knowledge of trauma care; and

(e) Registered nurses, licensed practical nurses, and nurse aides in sufficient number to provide appropriate coverage.

2706.4 The in-house team shall be on group call pagers to meet each patient with maximum readiness upon arrival. If the in-house team is not on group call pagers, a paging system shall function to mobilize the team within a maximum of two (2) minutes.

2706.5 The annual team responses for an adult Level I trauma center shall be at least twelve hundred (1200) patients, or a minimum of two hundred and forty (240) patients with an Injury Severity Score greater than fifteen (>15), or an average of more than thirty five (35) patients with an Injury Severity Score greater than fifteen (15) for all trauma panel surgeons.

2706.6 Repealed.

2706.7 Each adult trauma care facility shall have mobile X-ray capability with twenty-four (24) hours per day coverage by in-house technicians.

2707 TRAUMA RESUSCITATION AREA

2707.1 The emergency department of each adult trauma care facility shall have a large space designated and dedicated as the trauma resuscitation area. The space shall be large enough to allow assembly of the full trauma team plus necessary equipment including ventilators and a portable X-ray machine.

2707.2 Equipment may include ultrasound. Equipment or procedure trays to perform invasive treatments shall be available as follows:

(a) Airway control and ventilation equipment;

(b) Pulse oximetry;

(c) Suction devices;

(d) Electrocardiograph-oscilloscope-defibrillator;

(e) Internal paddles;

(f) Central venous pressure (CVP) monitoring equipment;

(g) Standard intravenous (IV) fluids and administration sets;

(h) Large-bore intravenous catheters;

(i) Sterile surgical sets for airway control, cricothyrotomy, thoracostomy, venous cutdown, central line insertion, thoracotomy, and peritoneal lavage;

(j) Arterial catheters;

(k) Drugs necessary for emergency care;

(l) X- ray availability twenty-four (24) hours per day;

(m) Cervical traction devices;

(n) Broselow tape;

(o) Thermal control equipment for the patient, fluids, and blood;

(p) Rapid infuser system;

(q) Qualitative end-tidal Carbon Dioxide (CO2) determination; and

(r) Communication with Emergency Medical Services (EMS) vehicles.

2707.3 The trauma resuscitation area shall contain adequate telephones, telephone lines, and intercoms.

2707.4 In Level I facilities, dedicated phone lines shall be used between the resuscitation area and the blood bank and operating room. Large wallboards shall display team members' names and roles, as well as key hospital phone numbers and on-call personnel.

2707.5 Each adult trauma care facility shall have the following communication capabilities:

(a) Pre-hospital to hospital link for direct medical command and early hospital notification;

(b) Trauma team alert and activation;

(c) Pre-hospital provider and trauma team information transfer;

(d) Trauma team and intrafacility personnel communication; and

(e) Interfacility communication.

2707.6 In each adult trauma care facility, the resuscitation trauma team shall consist of at least the following personnel:

(a) Surgeon (trauma team leader);

(b) Emergency physician;

(c) Anesthesia personnel;

(d) Nurses;

(e) Respiratory therapist;

(f) Radiologic technologist;

(g) Blood bank or laboratory personnel;

(h) Operating room staff;

(i) Critical care nurse;

(j) Security officer;

(k) Surgical and emergency residents;

(l) Chaplain; and

(m) Social worker.

2707.7 Each individual trauma team member shall assist in the assessment of the patient with simultaneous life support, diagnosis of injuries, acquisition of laboratory specimens, initial radiographic survey, and communication and mobilization of all necessary hospital resources.

2708 OPERATING SUITE

2708.1 Operating suites in each adult trauma care facility shall be staffed and equipped to handle each patient brought into the emergency department in need of immediate surgical intervention.

2708.2 Operating suites shall be immediately available twenty-four (24) hours per day. Operating suites in Level I facilities shall be staffed in-house. Operating suites in Level II facilities may be staffed in-house.

2708.3 Each operating suite in Level and Level II facilities shall have equipment suitable for use in adults, including:

(a) Thermal control equipment for patients, blood, and fluids;

(b) X- ray capability, including C-arm image intensifier available twenty-four (24) hours per day;

(c) Endoscope;

(d) Craniotomy instruments;

(e) Equipment appropriate for fixation of long-bone and pelvic fractures;

(f) Bronchoscope; and

(g) Rapid Infuser system.

2708.4 Each operating suite in a Level I facility shall have the following capability and equipment, in addition to the requirements set out in § 2708.3:

(a) Cardiopulmonary bypass; and

(b) Operating room microscope.

VII. Paragraph 2709.1(e) is amended by striking the phrase "End-tidal CO2 determination; and" and inserting the phrase "Reserved; and" in its place.

VIII. Section 2710 is amended as follows:

A. Amend subsection 2710.1 to read as follows:

2710.1 A hospital designated as a Level I trauma center shall have a surgically directed and staffed Intensive Care Unit (ICU).

B. Amend subsection 2710.2 to read as follows:

2710.2 In each adult trauma care facility, there shall be designated a surgical director or surgical co-director for the ICU.

C. Amend subsection 2710.4 to read as follows:

2710.4 Medical and surgical specialists shall be consulted as needed to provide specific expertise in the care of the patient in the ICU. The Surgical Intensive Care Unit (SICU) service physician must be in-house twenty-four (24) hours per day for Level I facilities.

D. Amend subsection 2710.6 by striking the phrase "Trauma Service Director" and inserting the phrase "Surgical Critical Care Service Director" in its place.

E. Amend subsection 2710.8 to read as follows:

2710.8 Each nurse assigned to trauma patients shall be a registered nurse, and shall hold certification as a CCRN or have evidence of equivalent critical care training from the American Association of Critical Care Nurses. Before assuming

responsibility for patients in the ICU, each nurse shall be oriented to the care of the critically ill trauma patient. Each nurse shall complete at least eight (8) hours of Continuing Medical Education (CME) each year.

F. Amend subsection 2710.11 to read as follows:

2710.11 Each ICU shall have support personnel available as follows:

(a) Respiratory therapists;

(b) Physical therapists;

(c) Discharge planners;

(d) Social workers;

(e) Interpreters;

(f) In-house radiology technologist;

(g) In-house acute hemodialysis;

(h) In-house Computerized Tomographic (CT) technician; and

(i) Angiographer, sonographer, magnetic resonance imaging (MRI) technician.

G. Amend paragraph 2710.12(d) to read as follows:

(d) Sets of instruments for the following procedures:

(1) Tracheostomy;

(2) Thoracostomy;

(3) Venous cut-down;

(4) Central venous puncture;

(5) Tracheal intubation;

(6) Intracranial monitoring equipment; and

(7) Pulmonary artery monitoring equipment.

IX. Subsection 2712.5 is amended to read as follows:

2712.5 The Burn Center shall admit an average over any three (3) year period of one hundred (100) or more patients annually with acute burn injures, and shall maintain an average daily census of three (3) or more patients with acute burn injuries.

X. Sections 2714 through 2716 are amended to read as follows:

2714 SPECIAL RADIOLOGICAL CAPABILITIES

2714.1 In Level I facilities, special radiological capabilities shall be available twenty-four (24) hours per day and shall consist of at least the following:

(a) In-house radiology technician;

(b) Angiography;

(c) Sonography;

(d) Nuclear scanning;

(e) Computerized tomography;

(f) In-house Computerized Tomography (CT) technician; and

(g) Magnetic Resonance Imaging (MRI).

2714.2 In Level II facilities, special radiological capabilities shall be available twenty-four (24) hours per day and shall consist of at least the following:

(a) In-house radiology technician;

(b) Angiography;

(c) Sonography; and

(d) Computerized tomography.

2714.3 In Level II facilities, special radiological capabilities may also include:

(a) Nuclear scanning;

(b) In-house Computerized Tomography (CT) technician; and

(c) Magnetic Resonance Imaging (MRI).

2715 CLINICAL LABORATORY SERVICE

2715.1 Clinical laboratory services in adult trauma facilities shall be available twenty-four (24) hours per day for the following:

(a) Standard analyses of blood, urine, and other body fluids;

(b) Blood typing and cross-matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to a community central blood bank and adequate storage facilities;

(e) Blood gases and potential of Hydrogen (pH) determinations;

(f) Microbiology.

2716 REHABILITATION MEDICINE

2716.1 Each adult trauma care facility shall have a physician-directed rehabilitation service program staffed by personnel trained in rehabilitation care and equipped properly for the care of the critically injured patient. This shall include the following:

(a) Physical therapy;

(b) Occupational therapy;

(c) Speech therapy; and

(d) Social service.

2716.2 Adult trauma care facilities shall have transfer agreements with approved rehabilitation facilities for long-term care.

XI. Section 2717 is amended as follows:

A. Strike the phrase "quality assurance" wherever it appears and insert the phrase "performance improvement" in its place.

B. Amend paragraphs 2717.1(g) and (h) to read as follows:

(g) Review of times and reasons for transfer of injured patients;

(h) Times of and reasons for trauma-related bypass documentation; and

C. Amend subsection 2717.6 by striking the phrase "In Level I facilities," and inserting the phrase "In each adult trauma care facility" in its place.

D. Amend subsection 2717.7 by striking all of the existing text and inserting the phrase "Repealed." in its place.

E. Amend subparagraph 2717.9(b)(3) to read as follows:

(3) Documented attendance at a multidisciplinary conference where either morbidity or mortality comprises more than fifty percent (50%) of the subject matter, and hospital peer review conferences that deal with care of injured patients; and

F. Amend paragraphs 2717.11(a) and (b) to read as follows:

(a) Audit filters shall be used to examine the timeliness, appropriateness, and effectiveness of care rendered to an individual patient, and the value of continuous or periodic use of these filters in the quality improvement program shall be reviewed regularly by individual trauma facilities. Minimum filters to be applied include the following:

(1) Selected complications, monitored as either trends or sentinel events. Trauma Service Directors shall select those complications for audit and review those complications that are frequent or severe in their cohort of trauma patients; and

(2) All trauma deaths.

(b) A focused audit shall be used periodically to examine the process of care;

G. Amend subparagraph 2717.11(g)(4) by striking the phrase "chief of trauma services." and inserting the phrase "Director of Trauma Services." in its place.

H. Amend subsection 2717.13 to read as follows:

2717.13 An adult trauma care facility shall satisfy the requirements of § 2717.11(g) by establishing a multidisciplinary review committee that shall require a quorum of a majority of the members at each meeting. The multidisciplinary review committee shall consist of the following members:

(a) Chairperson - Trauma Service Director;

(b) Trauma nurse coordinator;

(c) A representative of the neurosurgery department;

(d) A representative of the orthopedic surgery department;

(e) A representative of the emergency medicine department;

(f) A representative of the anesthesiology department;

(g) A staff pathologist;

(h) A staff radiologist; and

(i) A representative from rehabilitation medicine.

I. Add two new subsections numbered 2717.14 and 2717.15 to read as follows:

2717.14 The goals of a multi-disciplinary review committee shall be as follows:

(a) Review selective deaths;

(b) Review complications;

(c) Discuss sentinel events; and

(d) Review organizational issues on a regular basis and in a systematic fashion.

2717.15 The objectives of this multi-disciplinary peer review committee shall be as follows:

(a) To identify and resolve problems or specific issues; and

(b) To identify new policies or protocols and have the representatives from the various departments listed in § 2717.13 transmit the information back to their respective departments.

XII. Section 2718 is amended to read as follows:

2718 TRANSFER AGREEMENTS

2718.1 Level I facilities shall have transfer agreements with other facilities whereby the Level I facility serves as a receiving facility.

2718.2 Level II facilities shall have transfer agreements whereby the Level II facility serves as both a transferring and receiving facility.

2718.3 When interhospital transfer is in the patient's best interest, the treating physician shall ensure that the patient is optimally stabilized within the capabilities of the transferring institution. The facility shall stabilize each injury or physiologic derangement, such as respiratory distress or shock, before the transfer. The urgent needs of the patient who requires advance level trauma care shall supersede the requirement that patients be cared for within a specific provider network.

2718.4 Transferring physician responsibilities shall include:

(a) Identifying the patient needing transfer;

(b) Initiating the transfer process by direct contact with the receiving surgeon or physician;

(c) Initiating resuscitation measures within the capabilities of the facility;

(d) Determining the appropriate mode of transportation in consultation with the receiving surgeon or physician; and

(e) Transferring all records, results, and X-rays to the receiving facility.

2718.5 Receiving physician responsibilities shall include:

(a) Ensuring resources are available at the receiving facility;

(b) Providing advice or consultation regarding specifics of the transfer or additional evaluation or resuscitation prior to transport;

(c) Clarifying and identifying medical controls after the receiving facility agrees to accept the patient; and

(d) Identifying a process for transportation, allowing feedback from the receiving physician to the transport team directly or to the medical direction of the transport team.

2718.6 Patient transport management shall consist of the following care:

(a) Qualified personnel and equipment shall be available during transport to meet anticipated contingencies;

(b) Sufficient supplies shall accompany the patient during transport, such as intravenous (IV) fluids, blood and medications as appropriate;

(c) Vital functions shall be equally monitored;

(d) Vital functions shall be supported; for example, hemodynamics, ventilation, central nervous system, and spinal protection;

(e) Records shall be kept during transport; and

(f) Communication shall be kept with on-line medical direction during transport.

XIII. Section 2720 is amended to read as follows:

2720 CONTINUING EDUCATION

2720.1 Each adult trauma facility shall provide a formal program for Continuing Medical Education (CME) specifically addressing adult trauma care and for the following personnel:

(a) General surgery residency program participants;

(b) Advanced Trauma Life Support (ATLS) providers;

(c) Programs provided by hospital for the following:

(1) Staff or community physicians CME;

(2) Nurses;

(3) Allied health personnel; and

(4) Prehospital personnel.

2720.2 The Trauma Service Director shall demonstrate educational involvement in trauma by active participation as an instructor for the American College of Surgeons (ACS) of an ATLS course.

2720.3 General surgeons on the trauma team shall successfully complete the ACS ATLS Course.

2720.4 All members of the trauma team shall have at least sixteen (16) hours of trauma-related CME training annually. Fifty percent (50%) of these hours during any three (3) -year period shall be obtained outside the surgeon's own institution.

2720.5 Emergency physicians on the trauma team shall have at least sixteen (16) hours of trauma-related CME training each year. Trauma CME credit may be earned by attending regional or national meetings concerning trauma-related issues and from

in-house conferences, such as grand rounds and multidisciplinary conferences. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the physician's own institution.

2720.6 Neurosurgical members of the trauma team at Level and II facilities shall have at least sixteen (16) hours of trauma-related CME. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the surgeon's own institution.

2720.7 Orthopedic surgical members of the trauma team at Level I and II facilities shall have at least sixteen (16) hours of trauma-related CME annually. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the surgeon's own institution.

XIV. Section 2721 is amended by adding two new subsections numbered 2721.2 and 2721.3 to read as follows:

2721.2 Each Level I facility shall conduct at least twelve (12) education or outreach presentations over a three (3) year period.

2721.3 Each Level II facility may conduct at least twelve (12) education or outreach presentations over a three (3) year period.

XV. Section 2722 is amended as follows:

A. Amend subparagraph 2722.1(c)(3) to read as follows:

(3) Providing information resources and submission of results to the District of Columbia Department of Health; and

B. Amend subsections 2722.4 and 2722.5 to read as follows:

2722.4 In Level I facilities the requirements of § 2722.1(a)(4) shall be met in consultion with an epidemiologist or biostatistician.

2722.5 In Level I facilities the requirements of § 2722.1(b)(1) shall be met by performing special data collection projects as needed.

XVI. Subsection 2723.3 is amended to read as follows:

2723.3 A Level I facility shall periodically present research results at local, regional, and national society meetings and conduct ongoing studies approved by local human and animal research review boards. Each Level I facility shall demonstrate research productivity to include at least ten (10) peer-reviewed publications over a three (3) year period. These publications may pertain to any aspect of the trauma

program.

Comments on the proposed rules should be sent in writing to the Department of Health, Office of the General Counsel, 4th Floor, 825 North Capitol Street, NE, Washington, DC 20002, not later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained Monday through Friday, excepting holidays, between the hours of 8:30 A.M. and 4:45 P.M. at the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health (DOH), pursuant to sections 2(b) and 5 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983 (the "Act"), effective February 24, 1984 (D.C. Law 5-48, D.C. Official Code § 44-501 (b) and 44-504), and Mayor's Order 98-137, dated August 20, 1998, hereby gives notice of the adoption, on an emergency basis, of the following amendment to Chapter 28 of Title 22 of the District of Columbia Municipal Regulations (DCMR). The emergency and proposed rules amend Chapter 28 to change the standard of care in, and qualifications for certification of, Level I and Level II Pediatric Trauma Care Facilities.

This emergency action is necessary to enable the District's pediatric trauma center(s) to satisfy the requirements of the American College of Surgeons (ACS) when it conducts its re-certification inspections of the District's Level I trauma facility beginning on April 21, 2004. If the District fails to have amendments in place thirty (30) days before the inspections begin, the ACS will not be able to certify the District's Level I pediatric trauma facility. The emergency rules were first adopted on March 22, 2004, and became effective immediately on that date. However, because the Director of DOH has decided that a number of non-substantive changes need to be made to the emergency rules, the emergency rules were re-adopted with those changes on April 8, 2004, replacing the emergency rules adopted on March 22, 2004. The revised emergency rules became effective on April 8, 2004 and will expire on August 6, 2004, or upon publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever occurs first.

The Director also gives notice of his intent to take final rulemaking action to adopt this amendment in not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Pursuant to section 5(j) of the Act, the proposed rules are being transmitted to the Council of the District of Columbia, and the final rules will not become effective until the expiration of the forty-five (45) day period of Council review or upon approval by Council resolution, whichever occurs first, and publication of a notice of final rulemaking in the *D.C. Register*.

Chapter 28 (Pediatric Trauma Care) of Title 22 (Public Health and Medicine) (August 1986) of the District of Columbia Municipal Regulations is amended as follows:

I. Section 2800 is amended as follows:

A. Amend subsection 2800.1 by striking the word "if" and inserting the phrase ", provided" in its place.

B. Amend subsection 2800.3 to read as follows:

2800.3 An inclusive trauma care system is a system that is fully integrated into the EMS system and is designed to meet the needs of all injured patients requiring care in an acute care facility, regardless of severity of injury, geographic location, or

population density.

C. Amend paragraph 2800.4(k) by striking the phrase "Medical evaluation." and inserting the phrase "Research." in its place.

D. Amend subsection 2800.10 to read as follows:

2800.10 For optimal care of the severely injured, Level I and Level II facilities shall meet the following requirements:

(a) Skilled surgeons and other members of the trauma team shall be immediately available;

(b) When an arriving patient meets the hospital-specific guidelines defining a major resuscitation, the attending surgeon shall be present in the emergency department:

(1) Upon arrival of the patient, when there is advance notification from the field; or

(2) Within fifteen (15) minutes of activating the trauma team, when there is no advance notification;

(c) Compliance with the requirements of subsections (a) and (b) at a rate of eighty percent (80%) or greater shall be documented; and

(d) The following minimum criteria shall be used to define a major resuscitation:

(1) Hypotension: infant less than sixty (60) Systolic Blood Pressure (SBP), child less than seventy (70) SBP, and adolescent less than eighty (80) SBP;

(2) Glasgow Coma Scale less than eight (8) with hemodynamic instability;

(3) Penetrating injury with hemodynamic instability;

(4) Transfusion: interhospital transfer;

(5) Burns more than fifty percent (50%) of body surface;

(6) Vascular, thoracic, abdominal management;

(7) Hemodynamics Instability: infant less than sixty (60) SBP, child less than seventy (70) SBP, adolescent less than eighty (80) SBP, Oxygen saturation less than ninety-three percent (93%), and capillary refill more than four (4) seconds; and

(8) Discretion of Surgical Coordinator or Emergency Department (ED) attending physician.

II. Section 2802 is amended as follows:

A. Subsection 2802.15 is amended to read as follows:

2802.15 The Trauma Service Director shall make presentations on trauma care to medical staff and other health care organizations providing trauma care.

B. Subsection 2802.17 is amended to read as follows:

2802.17 Each pediatric trauma care facility shall have designated specialists available twenty-four (24) hours per day for the care of major trauma patients.

C. Subsections 2802.19 through 2802.23 are amended to read as follows:

2802.19 Each trauma surgeon in a pediatric trauma care facility shall have an interest in and a commitment to trauma care, demonstrated by participation in the organization of trauma protocols, trauma teams, trauma call rosters, and trauma rounds.

2802.20 General surgeons on the trauma team in pediatric trauma care facilities shall successfully complete the American College of Surgeons Advanced Trauma Life Support (ATLS) Course.

2802.21 Each surgeon member of the trauma team shall participate in a minimum of sixteen (16) hours of trauma-related continuing medical education (CME) courses per year. At least fifty percent (50%) of this CME shall be extramural, and both category I and category II CME may count toward satisfying this requirement.

2802.22 A physician's participation in regional groups, such as state and regional trauma committees, and membership in regional organizations, shall constitute significant involvement in and commitment to trauma-related matters.

2802.23 In each pediatric trauma care facility, the emergency physician shall be a member of the trauma team who participates in the care of the patient and in all audits and critiques necessary for excellence in trauma care.

D. Subsections 2802.25 through 2802.27 are amended to read as follows:

2802.25 An anesthesiologist shall have the overall responsibility for preoperative airway control of the patient during resuscitation, and act as postoperative consultant in cardiorespiratory support and pain control. An anesthesiologist on the trauma team shall satisfy the following requirements:

(a) Be appropriately certified;

(b) Have the necessary educational background in care of the trauma patient;

(c) Engage in trauma quality improvement; and

(d) Engage in investigative, teaching, and community activities.

2802.26 The emergency physician and anesthesiologist on the trauma team shall be board certified in their respective specialties as recognized by the American Board of Medical Specialties.

2802.27 In each pediatric trauma care facility, the following medical specialists shall be available for consultation in the area of patients with multiple injuries:

(a) Cardiologist;

(b) Pulmonary medicine;

(c) Respiratory therapy;

(d) Nephrologist; and

(e) Dialysis team.

(f) Repealed.

(g) Repealed.

(h) Repealed.

(i) Repealed.

(j) Repealed.

III. Paragraph 2803.2(f) is amended to read as follows:

(f) Assisting in maintaining a trauma registry, performing data collection, coding including external causes of injury, e-coding and scoring, and developing processes for validating data and submitting the data to the citywide trauma registry maintained by the District of Columbia Department of Health; and

IV. Section 2804 is amended as follows:

A. Paragraph 2804.1(a) is amended by striking the phrase "Pediatric Surgery;" and inserting the phrase "General Surgery;" in its place.

B. Paragraphs 2804.1(d) and (e) are amended to read as follows:

(d) Emergency Services; and

(e) Anesthesia.

C. Paragraphs 2804.1(f) through (j) are repealed.

D. Subsection 2804.2 is amended to read as follows:

2804.2 In each pediatric trauma care facility, a clearly identifiable neurosurgeon shall be promptly available when a patient needs to be seen. Immediate care necessitates a reliable on-call schedule with a specific protocol for back-up coverage.

E. Subsection 2804.4 is amended as follows:

1. The lead-in language is amended to read as follows:

2804.4 In each pediatric trauma care facility, the following minimum personnel and equipment required for the treatment of severe neurological trauma shall be on call and promptly available for the treatment of trauma patients at all times:

2. Strike the word "pediatric" in paragraphs (a) and (b)

3. Amend paragraph (c) to read as follows:

(c) Emergency department staffed twenty-four (24) hours per day by a physician who has successfully completed training in Advanced Trauma Life Support (ATLS) or who has demonstrated his or her level of expertise as determined by the Trauma Service Director;

4. Amend paragraph (f) to read as follows

(f) Intensive care unit (ICU) with appropriate equipment and staffing, including capabilities for monitoring intracranial pressure (ICP); and

F. Amend subsection 2804.6 by striking the word "pediatric".

G. Amend subsection 2804.9 to read as follows:

2804.9 The minimum qualifications of an orthopedic surgeon on-call shall include the following:

(a) Board certification (or eligibility during the first five (5) years after residency);

(b) Not less than sixteen (16) documented hours of Category I or II Continuing Medical Education (CME) per year in skeletal traumatology; and

(c) Participation in the facility's trauma service educational and quality improvement activities.

H. Amend subsection 2804.10 by striking the lead-in language and inserting the phrase "Orthopedic surgeon shall have demonstrated skill in:" in its place.

I. Amend subsection 2804.16 to read as follows:

2804.16 In each pediatric trauma care facility, a general orthopedist shall provide primary care for musculoskeletal injuries. When orthopedic trauma specialists are not immediately available, the initial orthopedic care may be provided by another member of the staff, who will then transfer that patient to the specialist. Interhospital transfer shall be required in appropriate cases.

V. Section 2805 is amended as follows:

A. Repeal paragraphs 2805.1(b), (c), and (f).

B. Amend subsection 2805.2 to read as follows:

2805.2 The evaluation and treatment of a patient may be started by a team of surgeons that includes, at a minimum, a post-graduate resident in at least the fourth (4th) year of training.

C. Amend subsection 2805.3 by striking the phrase "trauma quality assurance" and inserting the phrase "trauma performance improvement" in its place.

D. Subsection 2805.4 is amended to read as follows:

2805.4 An attending neurosurgeon shall be available and dedicated to that hospital's trauma service. This requirement may be satisfied by an in-house neurosurgery resident or physician who has special competence, as judged by the chief of neurosurgery, in the care of patients with neurological trauma, and who is capable of initiating measures to stabilize the patient and initiate diagnostic procedures.

E. Amend subsection 2805.5 as follows:

1. Amend the lead-in language by inserting the phrase "access to or" before the phrase "competence to".

2. Amend paragraph (a) to read as follows:

(a) Cardiac Surgery;

3. Amend paragraph (i) to read as follows:

(i) Internal Medicine;

4. Strike the word "and" in paragraph (l)

5. Strike the period at the end of paragraph (m) and insert a semicolon in its place, and add two new paragraphs numbered (n) and (o) to read as follows:

(n) Obstetrics-Gynecologic Surgery; and

(o) Thoracic Surgery.

F. Add three new subsections numbered 2805.11 through 2805.13 to read as follows:

2805.11 The requirement to provide emergency medical services may be satisfied by an emergency medicine chief resident capable of assessing emergency situations in trauma patients and providing any indicated treatment. When senior residents are used to satisfy availability requirements, the staff specialist on-call shall be advised and be available for consultations.

2805.12 The requirement to provide anesthesiology services may be satisfied in a Level I facility by an anesthesiology chief resident or a certified nurse anesthetist (CRNA) capable of assessing emergency situations in trauma patients, and providing any indicated treatment, including surgical anesthesia. When an anesthesiology resident or a CRNA is used to satisfy availability requirements, the staff anesthesiologist on-call shall be advised and be promptly available.

2805.13 The requirement to provide anesthesiology services is satisfied in a Level II facility when the staff anesthesiologist will be in the hospital at the time of, or shortly after, the patient's arrival. Before the staff anesthesiologist arrives, an Anesthesiology chief resident or a CRNA capable of assessing emergency situations in trauma patients and of initiating and providing any indicated treatment shall be available.

VI. Section 2806 is amended as follows:

A. Subsection 2806.2 is amended to read as follows:

2806.2 The requirement for an emergency medicine physician may be satisfied by an emergency medicine senior resident capable of assessing emergency situations in trauma patients and providing any indicated treatment. When a senior resident is used to satisfy this requirement the staff specialist on-call will be advised and will be promptly available. Supervision shall be provided by an in-house attending emergency physician twenty-four (24) hours per day in an institution where there is an emergency medicine residency training program.

B. Amend paragraph 2806.3(a) to read as follows:

(a) An emergency department attending physician with knowledge of trauma care who is Advanced Trauma Life Support (ATLS) Certified and may be Pediatric Advanced Life Support (PALS) Certified, or who has demonstrated an appropriate level of expertise as determined by the Trauma Service Director. An appropriate level of expertise is demonstrated with not less than sixteen (16) hours trauma-related Continuing Medical Education (CME), board certification, clinical involvement, and special interest in trauma.

C. Amend paragraph 2806.3(c) to read as follows:

(c) An anesthesiologist who shall be promptly available when the initial response is by an anesthesiology chief resident or a critical-care nurse anesthetist;

D. Amend subsection 2806.5 to read as follows:

2806.5 The annual team responses for a pediatric Level I trauma center shall be at least twelve hundred (1200) patients, or a minimum of two hundred and forty (240) patients with an Injury Severity Score of greater than fifteen (15), or more than thirty five (35) patients with an Injury Severity Score of greater than fifteen (15) on average for all trauma panel surgeons.

E. Repeal subsection 2806.6.

VII. Section 2807 is amended as follows:

A. Amend subsection 2807.2 to read as follows:

2807.2 Equipment may include ultrasound. Equipment or procedure trays to perform invasive treatments shall be available as follows:

(a) Airway control and ventilation equipment;

(b) Pulse oximetry;

(c) Suction devices;

(d) Electrocardiograph-oscilloscope-defibrillator;

(e) Internal paddles;

(f) Central venous pressure (CVP) monitoring equipment;

(g) Standard intravenous (IV) fluids and administration sets;

(h) Large-bore intravenous catheters;

(i) Sterile surgical sets airway control/cricothyrotomy, thoracostomy, venous cutdown, central line insertion, thoracotomy, peritoneal lavage;

(j) Arterial catheters;

(k) Drugs necessary for emergency care;

(l) X-ray availability twenty-four (24) hours per day;

(m) Cervical traction devices;

(n) Broselow tape;

(o) Thermal control equipment for patient, fluids, and blood;

(p) Rapid infuser system;

(q) Qualitative end-tidal Carbon Dioxide (CO2) determination; and

(r) Communication with Emergency Medical Service (EMS) vehicles.

B. Amend subsection 2807.6 as follows:

1. Amend paragraph (a) to read as follows:

(a) Surgeon (Trauma team leader);

2. Amend paragraph (g) by striking the word "and".

3. Amend paragraph (h) by striking the period and inserting a semicolon in its place, and add five new paragraphs numbered (i) through (m) to read as follows:

(i) Surgical and emergency residents;

(j) Critical care nurse;

(k) Security officer;

(l) Chaplain; and

(m) Social worker.

VIII. Section 2808 is amended as follows:

A. Subsection 2808.2 is amended to read as follows:

2808.2 Operating suites in Level I facilities shall be adequately staffed in-house and immediately available twenty-four (24) hours per day. Operating suites in Level II facilities may be adequately staffed in-house and immediately available twenty-four (24) hours per day.

B. Subsection 2808.3 is amended to read as follows:

2808.3 Each operating suite in Level I and Level II facilities shall have equipment suitable for use with children, including:

(a) Thermal control equipment for patients, blood, and fluids;

(b) X-ray capability, including C-arm image intensifier available twenty-four (24) hours per day;

(c) Endoscopes and a bronchoscope;

(d) Craniotomy instruments;

(e) Equipment appropriate for fixation of long-bone and pelvic fractures; and

(f) Rapid infuser system.

IX. Section 2809 is amended to read as follows:

2809 POSTANESTHETIC RECOVERY ROOM (PAR)

2809.1 In each pediatric trauma care facility, the postanesthetic recovery room (PAR), which may be the Surgical Pediatric Intensive Care Unit (PICU), shall be staffed and equipped as follows:

(a) Registered nurses and other essential personnel twenty-four (24) hours per day;

(b) Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange;

(c) Equipment for the continuous monitoring of intracranial pressure;

(d) Pulse oximetry; and

(e) Thermal control.

X. Section 2810 is amended as follows:

A. Amend subsections 2810.1 and 2810.2 to read as follows:

2810.1 A hospital shall have a surgically-directed and staffed Pediatric Intensive Care Unit (PICU) in order to be designated as a Level I trauma center.

2810.2 Each pediatric trauma care facility shall designate a surgical director or surgical co-director for the PICU.

B. Amend subsection 2810.4 to read as follows:

2810.4 Medical and surgical specialists shall be consulted as needed to provide specific expertise in the care of the patient in the PICU. The surgical PICU service physician shall be in-house twenty-four (24) hours per day in Level I facilities.

C. Amend subsection 2810.6 by striking the phrase "Trauma Service Director" and

inserting the phrase "Surgical Critical Care Service Director" in its place.

D. Amend subsection 2810.7 by striking the word "trauma" in the first sentence.

E. Amend subsection 2810.8 by striking the first sentence and inserting the sentence "Each nurse assigned to trauma patients shall be a registered nurse, and shall hold certification as a CCRN or have evidence of equivalent critical care training from the American Association of Critical Care Nurses." in its place.

F. Amend subsection 2810.11 to read as follows:

2810.11 Each PICU shall have support personnel available as follows:

(a) Respiratory therapists;

(b) Physical therapists;

(c) Discharge planners;

(d) Social workers;

(e) Interpreters;

(f) In-house radiology technologist;

(g) In-house acute hemodialysis;

(h) In-house computerized tomographic (CT) technician; and

(i) Angiographer, sonographer, magnetic resonance imaging (MRI) technician.

G. Amend subparagraphs 2810.12(d)(5) and (6) to read as follows:

(5) Tracheal intubation;

(6) Intracranial monitoring equipment; and

H. Add a new subparagraph 2810.12(d)(7) to read as follows:

(7) Pulmonary artery monitoring equipment.

I. Amend subsection 2810.13 by striking the phrase "primary provider" in the second sentence and inserting the phrase "primary physician" in its place

J. Repeal subsection 2810.14(n)

XI. Amend section 2811 by striking the phrase "renal replacement therapies" in each place it appears and inserting the phrase "hemodialysis services" in each place.

XII. Section 2812 is amended as follows:

A. Amend subsection 2812.4 by inserting the phrase "and each staff surgeon" after the phrase "Medical Director" in the last sentence.

B. Amend subsection 2812.5 to read as follows:

2812.5 The Burn Center shall admit an average over any three (3) year period of one hundred (100) or more patients with acute burn injuries annually and shall maintain an average daily census of three (3) or more patients with acute burn injuries.

C. Amend subsection 2812.7 to read as follows:

2812.7 The Burn Center shall have the following support personnel:

(a) Social worker;

(b) Dietitian;

(c) Respiratory therapists;

(d) Physical and occupational therapists;

(e) Psychologists;

(f) Clergy; and

(g) Repealed.

XIII. Section 2814 is amended as follows:

A. Paragraphs 2814.1(e) and (f) are amended to read as follows:

(e) Computerized tomography;

(f) In-house computerized tomographic (CT) technician; and

B. Add a new paragraph 2814.1(g) to read as follows:

(g) Magnetic resonance imaging (MRI).

C. Repeal paragraph 2814.2(e).

D. Amend subsection 2814.3 to read as follows:

2814.3 Special radiological capabilities in Level II facilities may also include:

(a) Nuclear scanning;

(b) In-house computerized tomographic (CT) technician; and

(c) Magnetic resonance imaging (MRI).

XIV. Repeal paragraph 2815.1(g).

XV. Amend subsection 2816.1 to read as follows:

2816.1 Each pediatric trauma care facility shall have a physician-directed rehabilitation service program staffed by personnel trained in rehabilitation care and equipped properly for the care of the critically injured patient, including, at a minimum, the following:

(a) Physical therapy;

(b) Occupational therapy;

(c) Speech therapy; and

(d) Social service.

XVI. Section 2817 is amended as follows:

A. Amend the heading to read as follows:

2817 PROGRAMS FOR PERFORMANCE IMPROVEMENT

B. Amend subsection 2817.1 to read as follows:

2817.1 Programs for performance improvement in a pediatric trauma facility shall have the following elements:

(a) Trauma registry;

(b) Special audit for all trauma deaths;

(c) Morbidity and mortality review;

(d) Multidisciplinary trauma conference;

(e) Medical nursing audit, utilization review, tissue review;

(f) Review of prehospital trauma care;

(g) Review of times and reasons for transfer of injured patients;

(h) Times of and reasons for trauma-related bypass documentation; and

(i) Quality improvement personnel specifically dedicated to the trauma service program.

C. Amend the lead-in language for subsection 2817.3 by striking the phrase "quality assurance" and inserting the phrase "performance improvement" in its place.

D. Amend subsection 2817.6 to read as follows:

2817.6 In Level I and Level II facilities, the Trauma Service Director shall be responsible for performance improvement.

E. Repeal subsection 2817.7.

F. Amend subsection 2817.9 as follows:

1. Strike the word "calls" in paragraph (a) and insert the phrase "care duties" in its place.

2. Amend subparagraph 2817.9(b)(3) to read as follows:

(3) Documented attendance at a multidisciplinary conference where either morbidity or mortality comprises more than fifty percent (50%) of the subject matter, and hospital peer review conferences that deal with care of injured patients; and

3. Amend subparagraph 2817.9(d)(2) by striking the phrase "an intensive care" and inserting the phrase "a pediatric intensive care" in its place.

G. Amend subsection 2817.11 as follows:

1. Repeal subparagraphs 2817.11(a)(1) through (10).

2. Strike the second sentence in paragraph (b) and repeal subparagraphs 2817.11(b)(1) through (5).

3. Amend paragraph (d) to read as follows:

(d) An internal review shall be conducted to identify patients to receive an in-depth peer review and audit. The in-depth review shall include charts of nonsurvivors who were expected to survive;

4. Amend subparagraph 2817.11(g)(4) by striking the word "is" and inserting the phrase "shall be" in its place.

H. Amend subsection 2817.13 to read as follows:

2817.13 To satisfy the requirements of §2817.11(g) a pediatric trauma facility shall establish a multidisciplinary review committee, which shall have a quorum of a majority of the members at each meeting. The multidisciplinary review committee shall consist of the following members:

(a) Chairperson - Trauma Service Director;

(b) Trauma nurse coordinator;

(c) A representative from neurosurgery;

(d) A representative from orthopedic surgery;

(e) A representative from emergency medicine;

(f) A representative from anesthesiology;

(g) A staff pathologist;

(h) A staff radiologist; and

(i) A representative from rehabilitation medicine.

I. Add two new subsections numbered 2817.14 and 2817.15 to read as follows:

2817.14 The goals of the multi-disciplinary review committee shall be as follows:

(a) Review selective deaths;

(b) Review complications;

(c) Discuss sentinel events; and

(d) Review organizational issues regularly and systematically.

2817.15 The objectives of the multi-disciplinary review committee shall be as follows:

(a) Identify and resolve problems or specific issues that need to be rectified; and

(b) Trigger new policies or protocols and have the representatives from the various departments listed in § 2817.13 transmit this information back to their respective departments.

XVII. Section 2818 is amended by adding three new subsections numbered 2818.4 through 2818.6 to read as follows:

2818.4 Transferring physician responsibilities shall include:

(a) Identifying the patient needing transfer;

(b) Initiating the transfer process by direct contact with the receiving surgeon or physician;

(c) Initiating resuscitation measures within the capabilities of the facility;

(d) Determining the appropriate mode of transportation in consultation with the receiving surgeon or physician; and

(e) Transferring all records, results, and x-rays to the receiving facility.

2818.5 Receiving physician responsibilities shall include:

(a) Ensuring resources are available at the receiving facility;

(b) Providing advice or consultation regarding specifics of the transfer or additional evaluation or resuscitation prior to transport;

(c) Clarifying and identifying medical control after the receiving facility agrees to accept the patient; and

(d) Identifying a process for transportation, allowing feedback from the

receiving physician to the transport team directly or to the medical direction of the transport team.

2818.6 Management during transport of patient:

(a) Qualified personnel and equipment shall be available during transport to meet anticipated contingencies;

(b) Sufficient supplies shall accompany the patient during transport, such as intravenous (IV) fluids, blood, and appropriate medications;

(c) Vital functions shall be equally monitored;

(d) Vital functions shall be supported; for example, hemodynamics, ventilation, central nervous system, and spinal protection;

(e) Records shall be kept during transport; and

(f) Communication shall be kept with on-line medical direction during transport.

XVIII. Sections 2820 and 2821 are amended to read as follows:

2820 CONTINUING EDUCATION

2820.1 A formal program for Continuing Medical Education (CME) specifically addressing pediatric trauma care shall be provided by the hospital for the following personnel:

(a) General surgery residency program participants;

(b) Advanced Trauma Life Support (ATLS) providers;

(c) Programs provided by hospital for the following:

(1) Staff or community physicians CME;

(2) Nurses;

(3) Allied health personnel; and

(4) Prehospital personnel.

2820.2 The Trauma Service Director shall demonstrate educational involvement in trauma by active participation as an instructor for the American College of Surgeons (ACS) of an ATLS course.

2820.3 General surgeons on the trauma team shall successfully complete the ACS ATLS Course.

2820.4 All members of the trauma team shall have at least sixteen (16) hours of trauma-related CME training annually. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the surgeon's own institution.

2820.5 Emergency physicians on the trauma team shall have at least sixteen (16) hours of trauma-related CME training each year. Trauma CME credit may be earned by attending regional or national meetings concerning trauma-related issues and from in-house conferences, such as grand rounds and multidisciplinary conferences. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the physician's own institution.

2820.6 Neurosurgical members of the trauma team at Level and II facilities shall have at least sixteen (16) hours of trauma-related CME. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the surgeon's own institution.

2820.7 Orthopedic surgical members of the trauma team at Level I and II facilities shall have at least sixteen (16) hours of trauma-related CME annually. Fifty percent (50%) of these hours during any three (3) year period shall be obtained outside the surgeon's own institution.

2821 OUTREACH PROGRAM

2821.1 Each pediatric trauma care facility shall be available for telephone and on-site consultations with physicians in the community and surrounding area regarding the care and treatment of trauma patients.

2821.2 Each Level I facility shall conduct at least twelve (12) education or outreach presentations over a three (3) year period.

2821.3 Each Level II facility may conduct at least twelve (12) education or outreach presentations over a three (3) year period.

XIX. Amend subparagraph 2822.1(c)(3) to read as follows:

(3) Providing information resources and submission of results to the District of Columbia Department of Health; and

XX. Section 2823 is amended as follows:

A. Amend subsection 2823.1 by inserting the word "trauma" after the word "injured" in the first sentence.

B. Amend subsection 2823.3 to read as follows:

2823.3 A Level I facility shall periodically present research results at local, regional, and national society meetings and conduct ongoing studies approved by local human and animal research review boards. Each Level I facility shall demonstrate research productivity to include at least ten (10) peer-reviewed publications over a three (3) year period. These publications may pertain to any aspect of the trauma program.

XXI. Subsection 2899.1 is amended as follows:
A. Strike the definitions for the terms "Major pediatric trauma patient", "Pediatric Trauma Center", "Pediatric Trauma Patient", "Pediatric Trauma Score", and "Pediatric Trauma Surgeon".

B. Add a new definition for the term "Trauma patient" to read as follows:

Trauma patient – a patient suffering injuries as a result of physical trauma.

C. Amend the definition for the term "Trauma Score/Injury Severity Score" to read as follows:

Trauma Score/Injury Severity Score or TRISS – the likelihood of patient survival based on a regression equation that includes patient age, injury severity score, revised trauma score, and the type of injury (blunt or penetrating).

Comments on the proposed rules should be sent in writing to the Department of Health, Office of the General Counsel, 4th Floor, 825 North Capitol Street, NE, Washington, DC 20002, not later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained Monday through Friday, excepting holidays, between the hours of 8:30 A.M. and 4:45 P.M. at the same address.

DISTRICT OF COLUMBIA DEPARTMENT OF TRANSPORTATION

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

DOCKET NO. 03-90-TS

The Director of the Department of Transportation, pursuant to the authority in sections 3, 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137; D.C. Official Code §§ 50-921.02, 50-921.04(3) and 50-921.05), and sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the adoption of the following emergency rulemaking which amends Chapter 40 of the Vehicles and Traffic Regulations (18 DCMR) to establish bus to excluded from the No left Turn restrictions from eastbound Independence Avenue to northbound 3rd street, S.W.

Emergency rulemaking action, pursuant to section 6(c) of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1206; D.C. Official Code § 2-505(c)), was necessary due to the permanent closure of the 300 block of Maryland Avenue, S.W., and the temporary closure of 4th and 7th Streets during special events, Metro has made changes in the routing of the P6, V8, 70, 13A and 13B services. It is necessary that buses traveling eastbound on Independence Avenue make a left turn onto 3rd Street. This emergency action is being taken to provide for the immediate preservation of the public health, safety and welfare because without this action, bus services to the area would be disrupted. The emergency rulemaking was adopted on April 1, 2004, and became effective immediately upon that date.

The Director also gives notice of intent to take final rulemaking action to adopt this amendment in not less than thirty (30) days from the date of publication of this notice in the D.C. Register.

These emergency rules will expire on July 30, 2004, or upon the publication of a Notice of Final Rulemaking in the D.C. Register, whichever occurs first.

Tile 18 DCMR, Section 4015, "NO LEFT TURN" RESTRICTIONS, Subsection 4015.1(a) Northwest Section, is amended by deleting the following from the list of locations where no vehicle shall make a left turn at any time:

"Eastbound Independence Avenue, S.W., so as to proceed northbound on 3rd Street".

Title 18 DCMR, Section 4015, "NO LEFT TURN" RESTRICTIONS, Subsection 4015.9 (a) Northwest Section, is amended by adding the following to the list of locations where no vehicles shall make a left turn at anytime, EXCEPT BUSES:

"Eastbound Independence Avenue, S.W., so as to proceed northbound on 3rd Street".

All persons interested in commenting on the subject matter in this emergency and

All persons interested in commenting on the subject matter in this emergency and proposed rulemaking action may file comments in writing, not later than thirty days (30) days after the publication of this notice in the D.C. Register, with the Department of Transportation, Traffic Services Administration, 2000 14th Street, N.W., 7th Floor, Washington, D.C. 20009 (Attention: Docket No. 03-90-TS). Copies of this proposal are available, at cost, by writing to the above address.