

**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 (4<sup>th</sup>) 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 (4<sup>th</sup>) 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 (CO<sub>2</sub>) 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 injuries, 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 consultation 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, 4<sup>th</sup> 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 (4<sup>th</sup>) 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 (CO<sub>2</sub>) 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, 4<sup>th</sup> 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 3<sup>rd</sup> 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 4<sup>th</sup> and 7<sup>th</sup> 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 3<sup>rd</sup> 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.

Title 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 3<sup>rd</sup> 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 3<sup>rd</sup> 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 14<sup>th</sup> Street, N.W., 7<sup>th</sup> 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.