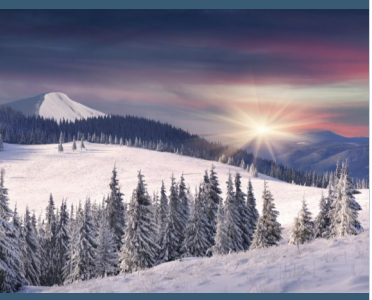
London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

Leadership of optimal prehospital care systems

SWORBHP LINKS

VOLUME 19 JANUARY 2015

Inside this issue:



A Winter Wonderland !

Paramedic Recognition Awards

Congratulations to the recipients of the 2014 **Medical Directors Award of Excellence** and **Medical Director's Commendation Award.**

Kevin McNab (Grey County EMS) received the Medical Directors Award of Excellence "For his work in advancing the practice of Paramedicine by advocating on behalf of paramedics in multiple agency strategic planning for the future. For demonstrating outstanding initiative in proposing valid constructive changes to the current structure of EMS with the end result of adopting improvements to the current system."

L to R...Warden Kevin Eccles, Dr. Don Eby, Kevin McNab, Chief Mike Muir

Prentice Scott and **Jamie Hamlin** (Essex-Windsor EMS) received the Award of Excellence "In recognition of outstanding clinical judgment and actions during a difficult and complicated clinical scenario."

L to R...Chief Bruce Krauter, Dr. Paul Bradford, Prentice Scott, Jamie Hamlin, Susan Kriening

Brodie Golem (Medavie EMS Elgin) received the Award of Excellence "In recognition of outstanding clinical judgment and actions during a difficult and complicated scenario."

L to R...Dr. Michael Peddle, Brodie Golem, Dr. Michael Lewell

Angelo Mariani (Medavie EMS Chatham-Kent) received the Medical Director's Commendation Award "For his professionalism in taking responsibility for patient safety."

L to R...Dr. Paul Bradford, Matt Gaudette, Angelo Mariani, Susan Kriening

At publication time, a total of 64 Prehospital Saves and 22 Prehospital Newborn deliveries had been confirmed for 2014. For a complete list of Recognition Award recipients, please click on the link below to our website. Congratulations everyone!

http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/OpsLogistics/ParamedicRecogAwards.htm

Cathy Prowd, CQIA
Operations & Logistics Specialist

ISSN: 1927-8276

Facilitating the delivery of excellent prehospital care while advancing safe practice and preparedness in our communities through collaborative partnerships and innovation.

Basic, But Complicated...

The Base Hospital Physicians have been hard at work with the MOHLTC revising the current Basic Life Support Patient Care Standards (BLS-PCS) and a new version should be completed in the near future. Apart from the sheer amount of time it takes to review this entire document, it amazes me how much medical literature and current concepts in patient care need to be assimilated into the final edition as well as the collaboration required between various stakeholder organizations to create consensus.

Take the recently released Field Trauma Triage Standard (FTTS) and Air Ambulance Utilization Standard (AAUS) as examples. Significant literature from trauma systems, helicopter EMS (HEMS) programs, position papers from EMS and Trauma Associations were reviewed to influence the final versions. Input and advice from the Ontario Base Hospital Group (OBHG), the Ontario Association of Paramedic Chiefs (OAPC), the Ontario Trauma Advisory Committee (OTAC), Ornge, and the MOHLTC among other groups, were required to edit the final documents: and that is just for two of the Standards!

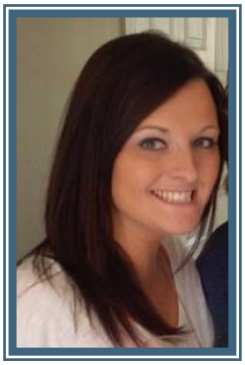
As you read this, best practice recommendations and stakeholder consultations are ongoing with such important topics as: C Spine immobilization decision rules and the role of “long boards”, oxygen administration overall but specifically including STEMI and COPD, hemorrhage control, IV fluid administration and monitoring, inter-facility transport, dispatch pre-arrival information, on scene physician interactions, obstetric deliveries and midwife/EMS interactions...the list of edits and changes literally goes on and on!

It is striking how much medical literature is focused at trying to determine the best approaches to the day to day practice of Paramedicine, yet we miscategorize these standards as “Basic”. As all of us who try to adopt an evidence based approach to our patient care understands, there is nothing “basic” about anything we do. Critically appraising the medical literature that may pertain to the patients we serve and assimilating the latest evidence into our clinical practice is complicated...but also super important.

Given the number of patients you will contact over the life of these new Standards, getting this right is crucial. This is why we are proud to do the work that we do behind the scenes supporting your profession.

Michael Lewell, B.Sc., M.D., FRCP(C)
Regional Medical Director

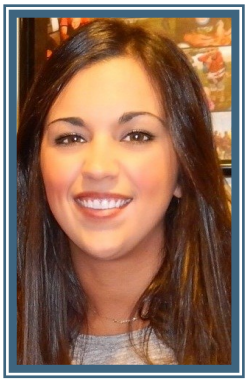
Introducing Our New SWORBHP Staff



Sara Gilbert joined SWORBHP in September 2014 as an Administrative Assistant to Dr. Mike Lewell (Regional Medical Director) and Sue Kriening (Regional Program Manager).

Sara holds an honors degree in Kinesiology from the University of Western Ontario as well as a diploma in Health Care Administration from Trios College.

Prior to working at Base Hospital, Sara practiced as a Kinesiologist for eight years before joining the Internal Medicine team at LHSC University Hospital in April 2013.



Julie Oliveira joined SWORBHP in December 2014 as the part-time Program Secretary. She provides support to Greg Graham, Coordinator of Professional Standards & Business Functions as well as Stephanie Romano, Coordinator of Education.

Julie continues to work in Bed Management and the Emergency Department at Victoria Hospital. In the past, she assisted in the launch and education of Patient Flow Management Solutions for LHSC and has also worked as an Administrative Assistant. Julie is currently completing her Business Marketing Diploma at Fanshawe College.

Please join us in welcoming Sara and Julie to the SWORBHP Team.

Treatment of Hypotension With an IV Saline Bolus

Over the last year the SWORBHP auditors and medical directors have struggled with a widespread paramedic practice of failing to treat hypotension with an IV fluid bolus. When paramedics are asked why they did not start an IV or give a fluid bolus to their patient with a systolic BP under 90, the answers generally fall into three categories. The most common one is "their BP is always low", then "they looked fine and were not symptomatic", and finally, "I did not believe the machine".

Blood pressure measurement in humans follows a continuous distribution that forms a Gaussian or "normal" distribution curve, i.e. a Bell curve. High and low blood pressures are arbitrarily defined as cut off points near each end of the curve. In the Ontario prehospital system a systolic BP of less than 90 systolic is the cut off point on the curve that defines hypotension. Some 'normal' adults will have blood pressures less than 90 but only approximately 2% or 1 in 50. Therefore, the vast majority of patients who are found to have BPs lower than 90 are truly hypotensive and should be treated.

"When a person has abnormally low blood pressure they have little physiological reserve left."

Sometimes it is difficult to get your head around treating someone who is 'asymptomatic' and looks well. One of the adages of clinical practice is "treat the patient, not the numbers" and most of the directives are set up to treat symptomatic patients. However, treating hypotension is different. When a person has abnormally low blood pressure they have little physiological reserve left. A small change in their state potentially causes them to deteriorate rapidly and therefore active treatment of low blood pressure is an important thing to do.

If for some reason a paramedic does not believe their equipment, take another reading. If that is also low and the reading is still not believed, the clinician should do a manual blood pressure. If that is low, treat the patient!

Hypotension, as defined as having a systolic BP less than 90, should be treated. It doesn't matter if the person "looks OK", "they are still talking to me" or "they are asymptomatic". Their reserve is low. Treatment potentially benefits the vast majority of patients who are found to be hypotensive. That is the reason treatment of hypotension is in the medical directives.

Don Eby, M.D., PhD., CCFP(EM), FCFP
Local Medical Director
Grey, Bruce, Huron, Perth

SWORBHP Undergoes Base Hospital Review

In September 2014, The Southwest Ontario Regional Base Hospital Program underwent its Ministry of Health and Long-term Care Emergency Health Services Branch Base Hospital Review. This review is mandated under the Ambulance Act, occurs every three years and is conducted by the Inspections and Certifications Branch of the EHSB. The purpose of the review is to ensure that each Base Hospital operates in a manner consistent with the Regional Base Hospital Performance Agreement. Each review is led by a member of the Inspections and Certification Branch and the reviewers are staff, leaders and physicians who work for other Ontario Base Hospitals.

SWORBHP received confirmation in November that we successfully met the Performance Agreement requirements for the operations/administration of a Base Hospital Program in the Province of Ontario. We were commended for our efforts in the areas of Host Hospital Requirements, Finance/Grant Funding, Continuous Quality Improvement Records, Policies and Procedures, Paramedic Education and Public Relations/Media.

We would like to acknowledge and thank our staff and physicians for all the preparatory work that ensured the success of our review. We would also like to thank the staff, leaders and physicians from the other Base Hospitals who participated in our review. By seeing our practices and processes through our peers' eyes, we are better able to make important improvements.

SWORBHP is proud to acknowledge that we have several of our own staff and physicians who participate in BH reviews. Dr. Don Eby, Dr. Paul Bradford, Cathy Prowd and Pete Morassutti are all reviewers and have participated in a number of our peers' reviews.

Susan Kriening, RN, BScN, MHS, ENC(C)
Regional Program Manager

Look for us on the Web
www.lhsc.on.ca/bhp

EMS and Hospitals Partner for Advanced Ebola Training

Our region has seen much effort in the last few months in joint planning and operational exercises in readiness for the threat of Ebola. With almost 21,000 cases identified in the world as of January 5, 2015, and over 8,000 deaths, it has brought back memories of our work with SARS (http://www.cdc.gov). There has been a definite push in individualized training focusing on familiarization with personal protective equipment (PPE) and also operational contingency planning as the province has revised and reworked our Provincial operational response plan. This has involved multiple agencies, and constant updates. Perhaps one of the more valuable efforts has been the use of joint operational planning drills. These have involved all the local agencies possible, beginning with table top exercises and evolving into real time drills in our actual work areas, while seeing non affected patients to allow for practical feedback and process improvement.

Essex-Windsor paramedics Mark Kobrosli and Tim Branch prepare to remove their contaminated gear (Doffing).

Several such drills were done with EMS, CACC, public health, and the hospitals in Windsor on November 3rd and 4th and again at both hospitals on December 16th, with EMS using the more advanced PPE and adjusting doffing strategies on hospital handover, while working through communication challenges ("Hospital learned a lot" 2014). Table top scenario work also involved all police, fire, and border agencies, as well as media, and the ministry of labour for any safety concerns.

Future work will involve prolonged transport times from hospital testing facilities to Ebola treatment centers. This will involve convoy and patient escort work. Members of the prehospital Windsor CBRNE team, and infectious disease at the hospital have played valuable roles as subject matter experts. SWORBHP has been involved in similar work throughout our region (http://www.lhsc.on.ca/bhp).

Paul Bradford, B.Sc., M.D., CCFP(EM), FCFP, CD
Local Medical Director
Essex-Windsor, Chatham-Kent

References:

http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html
Cross, B. (2014, November 4). Hospital 'learned a lot' from mock ebola drills. The Windsor Star. Retrieved from: http://blogs.windsorstar.com/news/hospital-learned-a-lot-from-mock-ebola-drills
http://www.lhsc.on.ca/About_Us/Base_Hospital_Program/ebola.htm

Essex-Windsor paramedics Mike Gobet and Tom LeClair load "patient" Gail Bradford into a waiting ambulance during a mock Ebola planning drill.

Missing the App?

We are very excited to share that a substitute for the SWORBHP Medical Directive App is here! Although our substitution is not a mobile App that you can download from the App Store of your smart phone or tablet, it will look and function just like one. We have created a PDF document that you can download onto your phone and use just like you could the App. Follow the simple steps below from your smart phone or tablet.

- Go to www.lhsc.on.ca/bhp from your smart phone or tablet
- Select the box called Medical Directives (see image above)
  - For Apple products - select 'Open in iBooks' - the file remains saved in 'iBooks' for future access
  - For Blackberry products - save the file - the file remains saved in 'Adobe Reader' for future access
  - For Android products - download and use the document reader available on your device to upload the file
- Scroll through to the table of contents, then click on/select the medical directive or area that you'd like to review

If there are other documents you would like to see created this way, please let us know. We hope you enjoy this new adaptation!

Stephanie Romano, MScEd., HBSc., AEMCA
Education Coordinator

SWORBHP Website…Did You Know?

1. **News and Updates**
   Our website is updated on a daily basis, so if you want to stay up-to-date about what's happening at SWORBHP, keep an eye on this section. Don't forget to subscribe to the email updates as well!
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program

2. **Paramedic Rounds**
   If you missed a webinar or would like a refresher on a certain topic, this is where you can find them! We also post details and registration information about upcoming webinars here.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/Paramedic_Rounds.htm

3. **Continuing Medical Education (CME) Process**
   We have recently implemented a new process for the application, submission and approval of CME. Information regarding the new process can be found on this page including the CME Approval Chart, FAQs, Policy and Procedure and Training Bulletin.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/cont_education.htm

4. **Medical Directives**
   An electronic copy of the Medical Directive Handbook can be found here. This handbook contains content from the Ministry of Health and Long-Term Care *Advanced Life Support Patient Care Standards*.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Medical_Directives/index.htm

5. **Ebola Preparedness & Updates**
   We have created this page as a resource for paramedics in order to stay up-to-date on MOHLTC training bulletins and other relevant information regarding the Ebola Virus Disease (EVD).
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/ebola.htm

6. **MEDList**
   This page contains lists of common medications that you may encounter when treating patients. They cover different types of medications for certain conditions and are updated on a bi-monthly basis.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/medlist.htm

7. **Meet Our Team**
   Being a regional program, we know it is unlikely that you will get a chance to meet everyone. This page contains a picture and brief bio about each team member so check it out and get to know your SWORBHP Team!
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Welcome/our_team.htm

8. **Reciprocity Process**
   As part of the movement to standardizing processes across Ontario, SWORBHP now recognizes the auxiliary directives that paramedics have obtained at other Base Hospitals. Information about this process and our reciprocity form can be found on this page.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/reciprocity_process.htm

9. **Self-Reporting**
   Our self-reporting process allows paramedics to report omissions/commissions related to medically delegated acts. Reporting can be done through our self-report hotline or email. For more information about our self-report, check out this page.
   Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Prof_Stnd/SelfReport.htm

10. **Tip of the Week**
    EMS is filled with tricks of the trade and our hope is to share these tips in order to improve patient care, save time, or at the very least, provide some interesting information. This page contains weekly tips on a number of different topics.
    Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/weekly_tips.htm

Michelle Priebe, CQIA
Web and eLearning Design Developer

Prehospital Acetaminophen for Headache?

We've noticed a trend; you're trying to help your patients, and we think this is great. However, our auditing process has identified a potential gap regarding how the newest analgesic medical directives were taught. We're seeing a number of patches to the Base Hospital Physician (BHP) where paramedics are requesting to administer acetaminophen, ibuprofen, morphine or fentanyl for patients with headache or fever, or to administer ketorolac to patients over the age of 50.

As logical as some of these requests seem, the analgesics you're carrying are not intended to treat headaches, fevers, or any other condition in the prehospital setting other than those described in the directives themselves. The age parameters within the directives are also very strict. That being said, you're likely going to see some changes with regards to these parameters in the near future; so hang in there, it's coming.

We absolutely understand the desire you have to help your patients, which is why you've either considered the phone call to the BHP, or actually made it. It might also be beneficial to appreciate the other side of the patch phone when a call comes in for a request for acetaminophen for a 42 year old female with a headache. Consider the physician who leaves the bedside of a patient in the ED, picks up a phone with a terrible connection and attempts to communicate with a paramedic who can also barely hear. I'm sure you've been there, and it's frustrating! So, let's keep the patching to the BHP for mandatory patches, medical direction for life or limb saving skills/techniques, and for advice when required.

By now you've probably completed your 2014-2015 recert, and you've likely already heard this message. If you have any questions regarding this, please don't hesitate to contact anyone within the SWORBHP team.

Stephanie Romano, MScEd., HBSc., AEMCA
Education Coordinator

SWORBHP MEDList - Antihistamines

As you know, histamine is released in response to the presence of an allergen. Reactions can be mild, moderate or severe, with severe cases resulting in anaphylaxis. Antihistamines are used to block histamine receptors and help relieve the symptoms associated with the mild or moderate reaction.

First generation antihistamines like Diphenhydramine tend to cause more side effects than others, however the list of potential side effects includes, but is not limited to drowsiness, dry mouth, dizziness, nausea, vomiting, restlessness, blurred vision and confusion.

Remember, if you've administered Diphenhydramine to a patient for a mild or moderate allergic reaction, do not administer Dimenhydrinate for nausea or vomiting in addition. Administering these medications together could potentially result in an anticholinergic excess causing dry mouth, mild hyperthermia, tachycardia, dilated pupils and CNS changes like confusion, sedation, paradoxical excitation, or even seizure (AskMAC, Nov 22, 2013).

Matthew Davis, M.D., M.Sc., FRCP(C)
Medical Director of Education

Link: www.lhsc.on.ca/About_Us/Base_Hospital_Program/Education/medlist.htm

Brand Name	Generic/Chemical Name	Medscape Reference
Atarax	Hydroxyzine	http://reference.medscape.com/drug/atarax-vistaril-hydroxyzine-343395
Allegra	Fexofenadine	http://reference.medscape.com/drug/allegra-fexofenadine-343393
Benadryl	Diphenhydramine	http://reference.medscape.com/drug/benadryl-nytol-diphenhydramine-343392
Dimetane	Brompheniramine	http://reference.medscape.com/drug/brompheniramine-343383
Clariten/Alavert	Loratidine	http://reference.medscape.com/drug/clarinex-reditabs-desloratadine-343396
Nighttime Cold/Flu	Chlorpheniramine	http://reference.medscape.com/drug/tylenol-allergy-multi-symptom-dristan-cold-acetaminophen-chlorpheniramine-phenylephrine-iv-999370
Aerius	Desloratadine	http://reference.medscape.com/drug/clarinex-reditabs-desloratadine-343396

Self-Reporting - Year Over Year Snapshot

The self-report hotline and email system has been in place since September 2010 to facilitate paramedic reporting of variation or issue on a call. Self-reported variances are handled quickly and usually require no remediation as the paramedic has already recognized the issue and hopefully made the adjustments to practice that remediation would involve. As these calls circumvent the regular auditing assignment process, efficiencies are gained through the self-reporting process.

Year over year (YoY) trending over the past two calendar years shows:

- Self-reports are up 7% YoY while time to close cases is down by 6% (**Chart 1**)
- Utilization, or take-up rate, has increased YoY
  - 18% of paramedics self-reported at least once in 2014, up from 17% in 2013
  - On a per call basis, self-reports have increased by 5%
- Significant variation in self-report utilization noted among the services with Elgin having the highest and Essex-Windsor the lowest (**Chart 2**)

Ongoing items of focus related to self-reporting include:

- Continuing to grow take-up rates across the services and reduce average time to case closed
- Investigate root cause behind lower take-up rates within several services and instances where utilization decreased YoY

Chart 1: YoY comparison of total self-reports and time to close

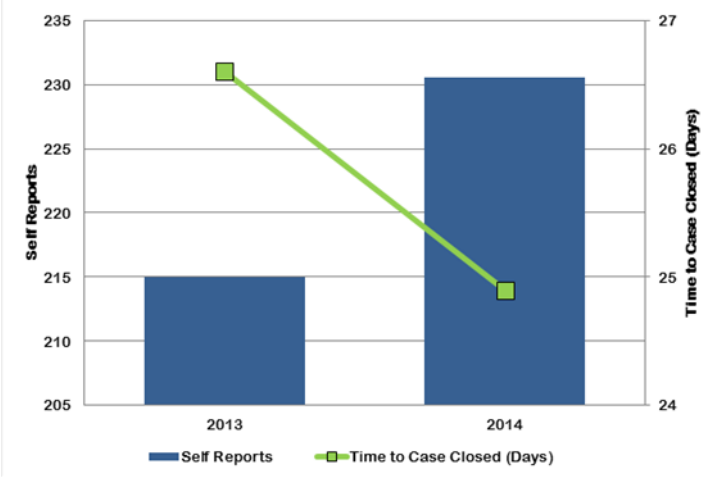
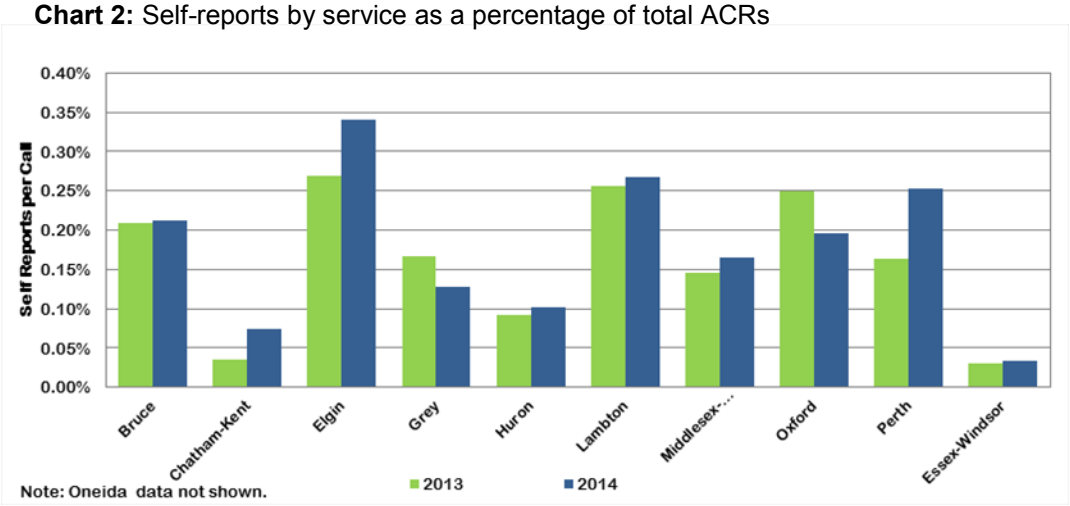


Chart 2: Self-reports by service as a percentage of total ACRs



Greg Graham, B.Sc., B.Ed., M.Eng.
Coordinator, Professional Standards & Business Functions

Paramedics, a Critical Link to Survival for Trauma Patients

The recent release by the MOHLTC EHS Branch of the revised *Field Trauma Triage and Air Ambulance Utilization Standards (FTTS/AAUS)* provides the opportunity for paramedics to reflect on how their understanding and application of these standards can impact outcomes for trauma patients. Much like the STEMI bypass programs that have been implemented in many regions in Ontario with the goal of reducing the time for patients to receive PCI and in turn improve outcomes, paramedic assessment and identification of severely injured trauma patients and determining the most appropriate receiving facility, which in the setting of traumatic injury is the Lead Trauma Hospital (LTH), is critical in reducing the mortality of these patients.[1] Key to a reduction in mortality is the time it takes for a trauma patient to reach definitive care at the LTH, a time that potentially may be reduced by utilizing air ambulance response.

Anecdotal experience suggests there is often confusion as to the appropriate application of the FTTS/AAUS and the processes that are in place to facilitate the movement of trauma patients to LTHs. The following case based on a recent call will attempt to highlight how the appropriate utilization of the FTTS/AAUS by the responding paramedics contributed to potentially saving the life of a 16 year old female patient who was involved in a single vehicle MVC.

Call Details

- Single vehicle MVC, two 16 year old female occupants.
- Land EMS arrived scene 16:45. Air ambulance requested by CACC based on MOI reports, ETA of 17:35 to the scene. Local ER is 15 minutes drive time, LTH is 2.5 hours.
- Vehicle travelling >80km/h on a country road, lost control on a bend in the road, left the roadway, struck an embankment, became airborne and landed on its roof in a field.
- Passenger has minor complaints of stiffness, self-extricates from the vehicle and calls 911.
- Driver (primary patient) suffers a LOC following the impact and is found by EMS still suspended upside down by her seatbelt, awake and talking but doesn't recall the event.
- Patient c/o moderate mid & lower back pain, left anterior chest pain which increases with palpation and deep inspiration, has an obvious left humerus fracture with intact distal CSM and is c/o mild generalized abdominal pain, with seatbelt markings noted on her abdomen.
- Vital signs at transport, HR 104, BP 116/70, RR 20, Sp02 95% on RA, GCS 15 but with no event recall.
- Land crew transports CTAS 2 to local ER.

In reading these call details as the responding land paramedic, does this patient need to be evaluated in a LTH? Would you choose to cancel the air ambulance or keep them coming if the aircraft has not arrived prior to your departure from scene?

In considering that decision, the patient suffered a significant MOI, but appears stable currently. She has several injuries as noted above and an increased HR but does not clearly meet the indications in Step 1: Physiological or Step 2: Anatomical criteria of the FTTS.[2] However, considering her injuries, and using the indications in Step 3, relating to high risk mechanism and in Step 4, special considerations which include patients <18 years of age, the crew decided to keep air ambulance responding to the local ER for a modified scene call.

Outcome

- Patient arrived in local ER at 17:25 and assessed by ER physician.
- Flight crew arrived in local ER at 17:45 with assessment of the patient ongoing.
- Exam and initial imaging reveals a fractured left humerus, fractures of ribs 3, 4, 5 on upper left chest, no hemo/pneumothorax noted. PT still c/o back and abdominal pain.
- During exam by flight crew, patient's HR increased to 125, BP decreased slightly to 108/64 and patient is extremely pale. Abdominal ultrasound (FAST) was performed indicating the patient had free fluid in her abdomen, an indicator of potentially life-threatening hemorrhage.
- PT was transported via air ambulance to a pediatric capable LTH, arriving at 18:45, 2 hours after her initial contact with EMS.

...continued on page 9

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Alternate Outcome

If it were not for the decisiveness of the responding paramedics in applying the FTTS/AAUS to identify this patient as benefitting from rapid transport to a LTH, the patient's arrival at the LTH would have been considerably delayed and the outcome may have been very different:

- If the air ambulance had been cancelled when the crew departed for the local ER, as so often happens, when the patient's injuries were eventually identified in the ER and air ambulance was requested again, with a 50 minute response time, it would have been a minimum two additional hours for this potentially unstable patient with a surgical abdomen to reach the LTH.
- If the air ambulance had not been available for whatever reason, this potentially unstable patient would have had to have been transported by land, approximately 2.5 hours to the LTH, with an RN and potentially an MD taken from the small sending facility to escort the patient during transport.

Conclusion

This case illustrates how the decision making of the paramedics within the confines of the FTTS/AAUS contributed to a positive outcome for a 16 year old trauma patient and may have saved her life by shortening the time it took for her to reach definitive care at the pediatric LTH. As you review the new FTTS/AAUS, please consider how we as paramedics can appropriately apply these principles to maximize the benefit for our trauma patients. If you have any questions regarding these standards please approach your Base Hospital educator for assistance.

Michael Kennedy, CCP(f)
Prehospital Care Specialist

References:

[1] Association Between Helicopter vs. Ground Emergency Medical Services and Survival for Adults with Major Trauma. JAMA, April 18, 2012 – Vol 307. No. 15:1602-1610.
http://jama.jamanetwork.com/article.aspx?articleid=1148152

[2] Basic Life Support Patient Care Standards – June 2014, Version 2.1, Section 1 – General Standard of Care

Upcoming CE Opportunities

- **Mental Health First Aid - March 12 & 13**
- **Capnography: Round 2 - March (date TBA)**

Click here to visit our website and view the page dedicated to Continuing Education.

Comments?

If you have comments or feedback on the newsletter, or have an article you would like to have considered for publication in a future edition of LINKS, please send to:

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