8th International Roundtable on Community Paramedicine
In combination with the
Emergency Medical Services Chiefs of Canada
Vancouver, 2012
Programme

Westin Bayshore
1601 Bayshore Drive, Vancouver, British Columbia V6G 2V4 Canada

FRIDAY June 15 2012

19.00 **Welcome Reception With Delegates of the EMS Chiefs of Canada**
(Meet in the Westin lobby at 6:45pm to group walk to reception.)
Location: Vancouver Aquarium
Aquaquest Reception
845 Avison Way
Vancouver, British Columbia

Chairs: **Gary Wingrove and Michael Nolan**

SATURDAY June 16 2012

08.30 **Session A**

8.A.1 **Welcome - Michael Nolan, President, EMS Chiefs of Canada**
Colin Carrie, Parliamentary Secretary to the British Columbia Minister of Public Safety
Les Fisher, COO, British Columbia Ambulance Service
Greg Mundy, CEO, Australasian Council of Ambulance Authorities
Neil Kirby, Director, Dubai Corporation for Ambulance Services
Gregg Margolis, US Department of Health & Human Services
Rick Patrick, US Department of Homeland Security

8.A.2 **Opening - Gary Wingrove, Chair, IRCP**
Recognition of Major Support: North Central EMS Institute
Recognition of Major Support: EMS Chiefs of Canada
Passing of the IRCP Gavel: Greg Mundy and Michael Nolan
Introduction of International Paramedic: Penny Price
Keynote: The Past, Present and Future of EMS.
Daniel Swayze, DrPH, Center for Emergency Medicine, University of Pittsburgh

10.00 **Morning Tea**

10.30 **Session B**

ROLE **8.B.1** *Insights from paramedics on their role and non-urgent interventions in traditional models of paramedic services: evidences to support practice changes* ***(Note: this presentation will be delivered in both French and English.)*** • Emmanuelle Bourdon, Primary Care Paramedic, MSc (c) Health Administration, TA-P Qc, BA, Paramedic Educator • Montréal (Québec) CAN [30]

PROGRAM **8.B.2** *Delivering medical services to a mass event in a remote location – Burning Man 2011* • Pat Songer, Advanced Care Paramedic • Nevada (Winnemucca) USA [60]

12.15 **Lunch**

12.45 **Session C**

ROLE **8.C.1** *An expanded model for community paramedicine in Western Australia* • Len Fiori • Western Australia (Belmont) AUS [30]

EVALUATION **8.C.2** *Demonstrating the value of community paramedicine programs, Part 1: The economist's view* • Ryan White • Colorado (Lone Tree) USA [30]

EVALUATION **8.C.3** *Paramedic services save lives* • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE [30]

14.30 **Afternoon Tea**

15.00 **Session D**

PROGRAM **8.D.1** *Meeting the health needs of Nova Scotia's communities* • Mark Wheatley, Advanced Care Paramedic • Nova Scotia (Dartmouth) CAN [30]

LAW **8.D.2** *The Planning, Creation, Reimbursement and Successful Implementation of a Statewide Community Paramedic Law: The Minnesota Experience* • OJ Doyle, Advanced Care Paramedic (ret.), BA • Minnesota (St. Paul) USA • Brennan ("Buck") McAlpin, Advanced Care Paramedic • Minnesota (Brooklyn Center) USA [30]

EVALUATION **8.D.3** *Demonstrating the value of Community Paramedicine Programs, Part 2* • Ryan White • Colorado (Lone Tree) USA [30]

SUNDAY June 17 2012

08.00 **Session E**

ROLE **8.E.1** *The Community Paramedic Curriculum: essential elements, development, review and monitoring, and next steps* • *Bill Raynovich*, Advanced Care Paramedic, EdD, MPH • Nebraska (Omaha) USA• *Anne Robinson*, RN • Colorado (Eagle) USA [60]

EVALUATION **8.E.2** *The future of paramedic services* • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE [30]

09.45 **Morning Tea**

10.15 **Session F**

PROGRAM **8.F.1** *Direct scene to catheterization lab: EMS transport is associated with improved outcomes for patients with ST-elevation myocardial infarction presenting in a rural community* • Mark Zandhuisen, Advanced Care Paramedic • Idaho (Sandpoint) USA [30]

ROLE **8.F.2** *Evaluating the impact of a community 24 hour flexible in-home support program by a multidisciplinary health care team on 911 calls.* • Michel Ruest, Advanced Care Paramedic • Ontario (Pembroke) CAN [30]

EVALUATION **8.F.3** *Demonstrating the value of Community Paramedicine Programs, Part 3* • Ryan White • Colorado (Lone Tree) USA [30]

12.00 **Lunch**
12:30 **Group Photo**

12.45 **Session G**

PROGRAM **8.G.1** *Immersive Education Demonstration* • Anne Robinson, RN, BSN, Colorado Eagle) USA • Kyle David Bates, Advanced Care Paramedic • New York (Tonawanda) USA [15]

PROGRAM **8.G.2** *The role of the specialist ambulance in paramedic services: a case study of the use of specialist ambulance in Dubai* • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE [30]

14.00 **Afternoon Tea**

14.30 **Session H**

PROGRAM **8.H.1** *Clinical review and mentoring (CRAM) model for evaluation of clinical changes and provider competency in an EMS system leads to operational consistency and supports evidence based practices* • Mark Zandhuisen, Advanced Care Paramedic • Idaho (Sandpoint) USA [30]

EVALUATION **8.H.2** *Overview of the North Central EMS Institute's Community Paramedic Technical Assistance Center* • *Anne Robinson*, RN • Colorado (Eagle) USA• *Chris Montera*, Advanced Care Paramedic • Colorado (Eagle) USA• *Gary Wingrove*, Advanced Care Paramedic (ret.) • Minnesota (Buffalo) USA [30]

15.45 **Conference Wrap Up**

MONDAY June 18 2012

08.00 **International Paramedic [Working Breakfast/Brunch Provided]**
12.00 **International Paramedic Adjourns**

Session Descriptions

8.B.1 Insights from paramedics on their role and non-urgent interventions in traditional model of paramedic services: evidences to support practice changes • Emmanuelle Bourdon, Primary Care Paramedic, MSc (c) Health Administration, TA-P Qc, BA, Paramedic Educator • Montréal (Québec) CAN

It has been recognized that the paramedic's role has steadily evolved. It has also been acknowledged that elderly and chronically ill user's demands lead to an increased number of prehospital non urgent interventions. But where does the paramedic's insight stands in all of this? Recent results from our qualitative study analysing Quebec paramedics' role conflict experience will be presented. Paramedics' views are supported by unpublished data on actual practice within Quebec province and urban region of Montréal/Laval. The research theoretical model demonstrates the conflict between the perceived role of a paramedic and the non-urgent intervention reality manifesting as a chronic-moderate organizational stress and its link to burnout and quality of care outcomes Paramedics describe how reality of their role is different than what is presented in training and actual definition of role, and their need to adapt to a perceived conflict. Copying mechanisms include cynical and disengagement attitudes but also for certain, personal initiatives to adjust practices to better address user's needs. Paramedic service administrators and the professional body will benefit from the use of these promising evidences to support development of the Community paramedic profile and changes in practice culture, also actions to lower stress in paramedics' experience and to enhance quality of care.

Study co-author: Nicole Leduc, PhD, Professor, Health Administration Department, Medicine Faculty, Montréal University

8.B.2 Delivering medical services to a mass event in a remote location – Burning Man 2011 • Pat Songer, Advanced Care Paramedic • Nevada (Winnemucca) USA

This presentation will explore the planning processes for delivering paramedic services to a mass event. The Burning Man Festival has been held in the Northern Nevada Black Rock Desert for the past 17 years. Obstacles of providing medical services in this remote desert location along with lessons learned will be shared, as well as cost savings and expanded medical services offered at the clinic.

8.C.1 An expanded model for community paramedicine in Western Australia • Len Fiori • Western Australia (Belmont) AUS

Health services in non-metropolitan Western Australia face the challenge of a very small population (350,000) distributed across a large land mass (2.5 million square kilometers). St John Ambulance (SJA) meets this challenge through a volunteer country ambulance service model. The Western Australia Country Health Service (WACHS) addresses the challenges of providing medical services in this environment through partnering with organisations like SJA.

To support the volunteer ambulance model, community paramedics work side by side with the broader health and emergency services organisations in close proximity to smaller rural centres. In addition to their principle goals in support of volunteers through training, recruitment and operational support, this model has included an innovative opportunities. The community paramedics work with WACHS

locally to develop joint initiatives that enhance overall health service delivery to remote communities.

At Wyndham, a remote community in the Kimberley, the community paramedic works alongside WACHS staff at the local health service assisting in the delivery of services at the hospital. At Karratha in the Pilbara the community paramedic liaises with remote mines sites to ensure integration of services between the mine, SJA and WACHS in major incident planning. Other illustrations exist across the state in other locations, including remote indigenous programs.

The driver behind the community paramedic role is recognition that the cost of deploying this resource, which is funded by WACHS, needs to be defrayed through a wider scope of practice than the traditional volunteer support model.

8.C.2 Demonstrating the value of community paramedicine programs (Note: this session is spread out over three time intervals – 8.C.2 - Part 1: the economist's view, 8.D.3 - Part 2 and 8.F.3 - Part 3) • Ryan White • Colorado (Lone Tree) USA

Regardless of a program's nation, region, population, or stage of development - funders, commercial and governmental payers, healthcare providers, and patients want to understand the value provided by the community paramedicine program. This three session presentation will focus on how to demonstrate value to the stakeholders of your paramedic service. Discussion will center on demonstrating value through economic savings, more efficiently allocating healthcare resources, providing high quality care, and proving better patient outcomes/health. This will be an interactive program with a presentation by the speaker on framing the concepts around demonstrating value. Then in a later breakout, participants will be asked to break into tables based on geography, demographics, national origin, or program focus to develop ideas around how to demonstrate value for their program. Later on the groups will report back and there will be a discussion period with the tables and the speaker to help further the conversation and spur an interchange of ideas among the participants.

8.C.3 Paramedic services save lives • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE

Paramedic services save lives. Great. But how do we measure the other 99% of what we do? What is the future of performance indicators for paramedic services and what are the performance indicators for community paramedicine?
Paramedic services historically were driven by response time performance measures. There has been substantial discussion in the literature that questions the value of this for a modern day paramedic service. There has been a call for some time for clinical outcome performance indicators, but what are they and how are they managed?
This paper will examine the current performance indicators that are commonly used and then look at where performance indicators are moving to in the future. What are the performance indicators for community paramedicine? How do we measure if we make a difference? What is the community expectation? How do ensure we compare apples to apples? And is it feasible to compare one variety of apple to another variety of apple?

Finally, we ask the question, how do we get international consensus on paramedic service benchmarks and performance indicators?

8.D.1 Meeting the health needs of Nova Scotia's communities • Mark Wheatley, Advanced Care Paramedic • Nova Scotia (Dartmouth) CAN

Meeting the health needs of Nova Scotia's communities: Community Paramedic Programs delivered by Emergency Health Services. This presentation will describe Emergency Health Services (EHS) delivery of various community paramedicine programs to meet the evolving needs of Nova Scotia's patient population. EHS, in collaboration with district health authorities and other health care professionals, has implemented three new unique programs. Each is designed to meet the specific needs of the community it serves, and to respond to gaps in the health system in which patients often lack timely access to primary and emergent health care.

This presentation will describe: [1] The Extended Care Paramedic program (Halifax region) serves the residents of 17 long term care (LTC) facilities. The paramedic works collaboratively with LTC physicians, nurses, families and patients to design a tailored emergency care plan, often avoiding transport to emergency. Research conducted on this program will be briefly presented. [2] In Collaborative Emergency Centres (5 locations in rural and remote communities), a nurse and paramedic work together to provide emergency services during overnight hours in local emergency departments, thereby providing residents with 'round the clock access to primary and emergent care. [3] In the VISIT (Vital signs, Interview, Safety Inspection, Treatment) program (Annapolis Royal), on-duty EHS paramedics perform senior's home visits, including falls assessments and treatment regime checks, in collaboration with the Annapolis Seniors Living Independently with Community Supports program.

This presentation will describe program delivery methods, goals of care and outcomes to date. Participants will hear about pearls to success for implementing such programs, and pitfalls to avoid.

8.D.2 The Planning, Creation, Reimbursement and Successful Implementation of a Statewide Community Paramedic Law: The Minnesota Experience • OJ Doyle, Advanced Care Paramedic (ret.), BA • Minnesota (St. Paul) USA • Brennan ("Buck") McAlpin, Advanced Care Paramedic • Minnesota (Brooklyn Center) USA

Approximately a decade ago, we initiated preliminary discussions with Minnesota legislators regarding creation of a Community Paramedic program. It was an unqualified disaster.

In 2010, we renewed our efforts. Although there was modest interest among some legislators, intense questioning made it apparent that we were not prepared for securing passage of a comprehensive legislative initiative. Subsequently, we invested 11 months drafting legislation and devising a strategy for what eventually became the first state Community Paramedic law in the United States. It was intended to be a two-part initiative: Establish Community Paramedic in statute in 2011; and, guarantee mandatory payment under the state's indigent care reimbursement program in 2012. Both laws have been enacted.

We will discuss initial steps and missteps, devising strategies for overcoming opposition from fourteen health provider advocacy groups; and, how the initiative was continually amended to meet stakeholder needs and to assure a well-crafted substantive law that preserved the integrity of the underlying concept. This session will include tips on dealing with opponents, establishing a formal training

curriculum, securing approval by the higher education regulatory authority in the state and assuring college credit.

Other successful strategies will be suggested on securing support of your state or provincial elected leadership and for dealing with legislative opponents. Last, we will present a means of successfully securing reimbursement through private insurance and other governmental and non-governmental payers.

8.D.3 Demonstrating the value of Community Paramedicine Programs, Part 2 • Ryan White • Colorado (Lone Tree) USA

See session 8.C.2*

8.E.1 The Community Paramedic Curriculum: essential elements, development, review and monitoring, and next steps • Bill Raynovich, Advanced Care Paramedic, EdD, MPH • Nebraska (Omaha) USA• Anne Robinson, RN • Colorado (Eagle) USA

Is it time for a standardized "universal" Community Paramedic curriculum? What elements should be included in a worldwide curriculum? Which regional curricula would be the best models for the worldwide curriculum? How would the integrity of the curriculum be maintained? How would changes be implemented and how would compliance monitored? These are just a few of the questions that have come of age. This presentation will discuss the essential elements of a curriculum and describe how the curriculum fits into instruction with regard to goals, objectives, lesson plans and performance outcome measures. Further discussion will consider modes of delivery, including traditional instruction, distance instruction (e.g., online learning), and recognition of alternate modes of study and credentialing.

8.E.2 The future of paramedic services • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE

Will the paramedic service of 50 years from now be different? What will the future paramedic service look like? Will it evolve or will it transform? Will the role change significantly? Will we do things differently?

This will be an interactive discussion on what the ambulance service of 2050 may look like. It will identify:

- What are the drivers for change?
- What are community expectations?
- Will clinical needs change?
- Will are always need an ambulance service?
- Is there a radically different way paramedic services can be provided?
- Will we always need a paramedic?

The group discussion will produce a vision of the ambulance service of 2050.

8.F.1 Direct scene to catheterization lab: EMS transport is associated with improved outcomes for patients with ST-elevation myocardial infarction presenting in a rural community • Mark Zandhuisen, Advanced Care Paramedic • Idaho (Sandpoint) USA

Primary percutaneous coronary intervention (PCI) is the standard of care for the management of ST-elevation myocardial infarction (STEMI) patients. Rural communities have diverse challenges often preventing the use of primary PCI due to unacceptable delays in evaluation and transport. We describe a progressive STEMI Alert plan wherein STEMI patients are transported by ground ambulance directly from the field to a regional hospital for PCI. Important elements include: cell phone transmission of EKGs, early activation of the PCI team, bypassing both local and regional emergency departments (ED), and direct communication of the paramedic and the accepting cardiologist. We evaluated the change in the EMS to balloon times (E2B), length of stay and mortality in 32 patients treated traditionally, as compared to the first 18 persons managed with this program. Between 1/09 and 11/10, 32 STEMI patients were transported. For those requiring immediate PCI, the average E2B was 173 minutes including an average time of 80 minutes in the local ED. Average length of stay (LOS) for STEMI patients was 4.5 days. Thirty day mortality was 16.7%. Under the new plan, the E2B dropped to 109 minutes, with a 12 minute scene time. LOS decreased to 2.7 days, with 0% mortality. Direct scene to cath lab transport for STEMI patients is a viable option for rural communities when using early EKG transmission, early activation of the PCI team, pre-hospital care provided by critical care paramedics in communication with a cardiologist, and bypassing time-consuming ED care. These strategies decrease E2B and improve patient outcomes.

Research Authors: R. Mark Zandhuisen, Advanced Care Paramedic, Clinical Operations Captain, Bonner County Emergency Medical Services, (BCEMS) Sandpoint, Idaho, USA; Ronald D Jenkins, MD, Medical Director, BCEMS, Sandpoint Idaho, USA; Dennis B Cooke MD, Kevin M Kavanaugh, MD, Belinda A Childers, RN, Kootenai Health, Coeur D'Alene, Idaho, USA; Frank A Rinella IV, Advanced Care Paramedic, Clinical Coordinator BCEMS, Sandpoint, Idaho, USA; Robert G Wakeley, Advanced Care Paramedic, Chief of BCEMS, Sandpoint, ID, USA; Kenneth J Gramyk, MD, Bonner General Hospital, Sandpoint, Idaho, USA

8.F.2 Evaluating the impact of Community Paramedics in the 24-hour flexible in-home support housing on 911 calls • Michel Ruest, Advanced Care Paramedic • Ontario (Pembroke) CAN

Collaboration of paramedic services and community organizations such as primary health care providers, social service agencies, and public safety groups can enable innovative initiatives that have the potential to improve the level of health care within a community and reduce health care system pressures. The purpose of this research is to evaluate the impact of an 'Aging at home' program using an integrated health care team involving Community Paramedics on 911 calls. Methods: This study involved a retrospective chart review of clients participating in the 'Aging at Home' program located in a rural community in Ontario between January 1, 2010 and April 30, 2011. Each record was evaluated for chief complaint, treatment rendered and whether transport to a local hospital emergency department was initiated by utilizing 911. Results: Of the 129 client interventions by paramedics and PSW, 15 resulted in ED visits by utilizing 911. Conclusion: The use of community paramedics in an integrated health care team aimed at supporting clients living at home decreased the utilization of 911 calls by 24.2% when comparing the time period of eight (8) months prior to the study period and eight (8) months after the study period.

Authors: Michel Ruest, Deputy Chief, County of Renfrew Paramedic Service; Amber Stitchman, Advanced Care Paramedic, County of Renfrew Paramedic Service; Chris Day, Primary Care Paramedic, County of Renfrew Paramedic Service

8.F.3 Demonstrating the value of Community Paramedicine Programs, Part 3 • Ryan White • Colorado (Lone Tree) USA

See session 8.C.2*

8.G.1 Immersive Education Demonstration • Anne Robinson, RN, BSN, Colorado Eagle) USA • Kyle David Bates, Advanced Care Paramedic • New York (Tonawanda) USA [15]

This session will be a demonstration of an emerging online education system that uses virtual reality.

8.G.2 The role of the specialist ambulance in paramedic services: a case study of the use of specialist ambulance in Dubai • Neil Kirby, ASM, MPH, B. Bus (HRD), BA, Ass Dip App Sc (Ambulance) • Dubai UAE

There has been an evolution of paramedic services toward higher clinical skills, mostly orientated to advanced cardiac, respiratory and trauma care. Of more recent times there has been a focus on specialized care. This is not a new concept, but some of the specialties are. In 2009, the Dubai Corporation for Ambulance Service created the Maternity and Childhood Care Unit, to provide for obstetric and neonatal emergencies. Since the commencement, a second unit has been added. There has been a significant increase in obstetric cases. The paper will review the effectiveness of such speciality units.

Another form of specialist unit is the geographical specific unit. An example is Dubai Airport, where a large team of paramedics provide dedicated coverage to staff, passengers and visitors to Dubai Airport. The paper also examines the effectiveness of this model in terms of providing paramedic care to the community.

What is the impact of specialized paramedic services on community paramedicine? Is the future of paramedic services in providing specialized care? Does the specialized role of these paramedics create issues in terms of skill retention or coverage to the wider community?

8.H.1 Clinical review and mentoring (CRAM) model for evaluation of clinical changes and provider competency in an EMS system leads to operational consistency and supports evidence based practices • Mark Zandhuisen, Advanced Care Paramedic • Idaho (Sandpoint) USA

Purpose: Prior to implementation of the CRAM program at BCEMS clinical changes were primarily vendor driven; the agency had no clear way to draw from the knowledge and experience of field providers for its betterment, and there was no consistent pathway to ensure the clinical competency of newly hired providers, or providers advancing in certification level. A program was needed to address those issues.

Methods: A CRAM committee was formed of interested providers across the various agencies of the BCEMS system. A process was developed for field providers to propose new products and ideas to the CRAM committee, where innovations are then critically evaluated using evidence based medicine. Another process was created in which newly hired and advancing providers are paired with mentors

overseeing their progress as they work with rotating preceptors, earning points based on call volume and performance. Once the point threshold is reached, and the mentor confirms clinical competency, the candidate is proposed to the CRAM committee which evaluates their performance and votes to recommend clearance for independent practice to the Medical Director. A review of the minutes from CRAM meetings was performed.

Results: During August 2011 to April 2012 seven meetings were held. 8 newly hired and advancing providers were presented for clearance for independent practice, and 11 innovations from providers were critically evaluated during that time.

Conclusions: The CRAM program model may be an effective tool for supporting evidence based practices, and consistency in evaluating newly hired or advancing provider competency in EMS systems.

8.H.2 Overview of the North Central EMS Institute's Community Paramedic Technical Assistance Center • Anne Robinson, RN • Colorado (Eagle) USA• Chris Montera, Advanced Care Paramedic • Colorado (Eagle) USA• Gary Wingrove, Advanced Care Paramedic (ret.) • Minnesota (Buffalo) USA

IRCP QUICK SCHEDULE

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19.00 **Welcome Reception With Delegates of the EMS Chiefs of Canada**

SATURDAY June 16 2012

08.30 **Session A (Welcome, Opening)**
10.00 **Morning Tea**
10.30 **Session B**

8.B.1 *Insights from paramedics on their role and non-urgent interventions in traditional models of paramedic services: evidences to support practice changes*
8.B.2 *Delivering medical services to a mass event in a remote location – Burning Man 2011*

12.15 **Lunch**
12.45 **Session C**

8.C.1 *An expanded model for community paramedicine in Western Australia*
8.C.2 *Demonstrating the value of community paramedicine programs, Part 1: The economist's view*
8.C.3 *Paramedic services saves lives*

14.30 **Afternoon Tea**
15.00 **Session D**

8.D.1 *Meeting the health needs of Nova Scotia's communities*
8.D.2 *The Planning, Creation, Reimbursement and Successful Implementation of a Statewide Community Paramedic Law: The Minnesota Experience*
8.D.3 *Demonstrating the value of Community Paramedicine Programs, Part 2*

SUNDAY June 17 2012

08.00 **Session E**

8.E.1 *The Community Paramedic Curriculum: essential elements, development, review and monitoring, and next steps*
8.E.2 *The future of paramedic services*

09.45 **Morning Tea**
10.15 **Session F**

8.F.1 *Direct scene to catheterization lab: EMS transport is associated with improved outcomes for patients with ST-elevation myocardial infarction presenting in a rural community*
8.F.2 *Evaluating the impact of Community Paramedics in the 24-hour flexible in-home support housing on 911 calls*
8.F.3 *Demonstrating the value of Community Paramedicine Programs, Part 3*

12.00 **Lunch**
12.30 **Group Photo**
12.45 **Session G**

8.G.1 *Immersive Education Demonstration*
8.G.2 *The role of the specialist ambulance in paramedic services: a case study of the use of specialist ambulance in Dubai*

14.00 **Afternoon Tea**
14.30 **Session H**

8.H.1 *Clinical review and mentoring (CRAM) model for evaluation of clinical changes and provider competency in an EMS system leads to operational consistency and supports evidence based practices*
8.H.2 *Overview of the North Central EMS Institute's Community Paramedic Technical Assistance Center*

16.00 **Conference Wrap Up**