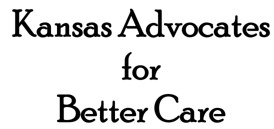

Pain Management

guide for caregivers

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Introduction

Why talk about pain?

Pain is one of the most frequent complaints of the elderly, yet pain management in the elderly or long-term care setting is often overlooked or not recognized. Results of effective pain management are positive and observable through increased comfort and improved quality of life for the frail adults.

Why is pain management important?

- 45.4% of Kansas nursing home residents live with persistent pain.
- 25% of those don't even get an aspirin.
- 86% of terminally ill Kansans experience moderate to excruciating pain during the last three months of their lives.

Source: Kansas LIFE Project Pain Management Advocacy Toolkit, p. 20, (Brown University, 2002).

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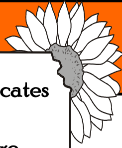

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The Who, What, Why, When, Where of Pain Management

WHO - Front line nursing staff

The role of the Certified Nursing Assistant (CNA) in the initial assessment and reassessment of the resident includes responsibilities such as:

- Utilize a standard pain intensity scale/score
- Indicate the location/s of the pain
- Report observations to the nurse in a timely manner
- Report status of pain following interventions
- Understand the importance of regular ongoing reassessment
- Report indicators of pain
  - a) changes in any of the following: behavior, ADL's, appetite, sleep pattern, mobility, weight loss
  - b) effect of medication and other interventions during caregiving, particularly transfers, and determine if the desired result was obtained
- Know how pain was expressed in the past, particularly with the severely cognitively impaired resident
- Use of non-drug therapy in the treatment of pain
  - a) Reposition residents for comfort with correct body alignment
  - b) Utilize distraction techniques in routine caregiving
  - c) Assist with basic relaxation techniques per plan of care
- Advocate for effective pain management

Who -Other front line staff

Why talk to *all* staff about pain, not just nursing staff? The nursing home should have commitment to provide maximum pain relief for all residents. Gaining input from all staff helps assure that pain is recognized, documented, treated properly.

1. Dietary staff can notice residents
   - a) Changes in appetite
   - b) Ability to feed self
   - c) Interactions with friends at meals
   - d) Topics of casual conversations with staff
2. Housekeeping staff can detect concerns during casual conversations with residents
3. Maintenance staff can use casual conversation, and general observation
4. Office staff can detect via daily conversation
5. Therapeutic recreation staff can notice a resident's
   - a) Ability to participate in activities - movement, dexterity
   - b) Willingness to attend activities

Source: Pain Management Resource Manual, pp. 33-35 and 171-173.

WHAT – Pain management for acute and chronic pain

Concept of Pain

A. Must accept residents' reports of pain

1. "Pain is whatever the experiencing person says it is, existing wherever the experiencing person says it does." (Margo McCaffery*, Nursing Practice Theories*, 1968)
2. Pain is unique to each individual; is difficult to measure by any means other than the individual's own report; is best treated when all interventions are based on the patient's report of pain. (This is the gold standard.)

B. Fear of addiction can be a serious barrier to good pain management.

1. Pseudo-addiction is a pattern of drug-seeking behavior of pain patients who are receiving **inadequate pain management.** This behavior can be mistaken for addiction.
2. Addiction
   a) "A neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use, despite harm."
   b) "Results in psychological dependence on the use of substance for their psychic effects." **People with addiction problems don't use drugs to get pain relief.** They are using them to change the way they feel. They want to feel either "high" (inappropriately good or bad) or feel numb (because their lives make them so miserable, they just want to escape.)
   c) "Characterized by compulsive use despite harm to the user." These folks begin to lose things as they continue their drug abuse. They lose their jobs, their families, their homes, perhaps even their lives. Yet, they can't stop abusing drugs. They have completely lost their ability to control their use of the drugs.

Source: Kansas LIFE Project Pain Management Toolkit, pp. 7-10 and 14.

WHY ~ "Every Kansan Deserves Good Pain Management"

Consequences of ongoing pain to the individual result in:

- Increasing disability and decline
- Increasing discomfort
- Decreasing functional ability
- Decreasing quality of life

Source: Pain Management in the Nursing Home, p.1.

WHEN ~ Now…

"Pain - the 5th Vital Sign" is being promoted by these organizations:

- The Kansas Foundation for Medical Care, Inc. (KFMC)
- Case Management Society of America - KC Chapter
- DPA Associates
- Kansas Adult Care Executives
- Kansas Association of Homes and Services for the Aging (KAHSA)
- Kansas Department on Aging (KDOA)
- Kansas Department of Health and Environment (KDHE)
- Kansas Health Care Association (KHCA)
- Kansas Hospital Association
- Kansas Long-Term Care Ombudsman Office (SLTCO)
- Kansas Physical Therapy Association
- Living Initiatives for End-of-Life Care (LIFE Project)

Source: Pain Management Pocket Guide, KFMC

WHERE ~ Nursing homes, assisted living homes, and other licensed adult care homes

Health Care Professionals Emphasize Pain Management

Joint Policy Statement of the Kansas Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain, 2002

- "The boards adopt this statement to help assure healthcare providers, and patients and their families that it is the policy of this state to encourage competent comprehensive care for the treatment of pain."
- "The joint statement acknowledges that a patient's report of pain should be the optimal standard upon which all pain management programs are based."
- "Inappropriate treatment of pain is a serious problem… [and] includes nontreatment, undertreatment, overtreatment, and ineffective treatment."
- "Prescribing, administering, or dispensing controlled substances...to treat pain is considered a legitimate medical purpose if based upon clinical grounds."
- "Health care providers who competently treat pain should not fear disciplinary action from their licensing board."
- Kansas licensing boards are the first in the nation to issue a joint statement on the use of controlled substance for the treatment of pain that addresses pain of all kinds - chronic, acute and/or at the end of life.

Kansas State Board of Nursing Guideline for Pain Management,

adopted July 11, 2001 intentions:

- Promote the optimal level of nursing practice.
- Establish a standard of practice.
- Reassure nurses that following these guidelines means they will be supported, not sanctioned.
- "All persons who are experiencing pain have the right to have their pain relieved to the greatest extent possible."
- "A person's perception of pain is the optimal standard upon which all pain management is based."
- "Fear of addiction...need not be a barrier to pain management."
- "Persons with a history of substance abuse have the right to adequate pain relief, even if opioids must be used. Such persons require specialized care and treatment."
- "Continuity of care… is essential."
- "Pain management continues even if the person becomes unresponsive."
- "Sedation is an acceptable means of controlling pain and discomfort when all other reasonable efforts have failed."
- "Assisted suicide and euthanasia are illegal in...Kansas and are not acceptable alternatives to optimal pain management."

Source: Person Centered Pain Management Conference

Definitions Pertaining to Pain

Acute pain is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and responsive to opioid therapy, among other therapies.

1. Less than 6 months duration
2. Follows injury, disappears when healing occurs
3. Example: fractures, surgery, trauma
4. Characteristics: Crying, moaning, rocking, increased pulse and blood pressure, pallor

Addiction is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as “drug dependence” and “psychological dependence.” Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.

Chronic pain is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.

1. Longer than 6 months duration
2. Multiple pain sites
    a) Example: arthritis, old fractures, diabetic neuropathy, cancer, degenerative joint disease
3. Characteristics
    a) Adapt to pain over time, do not look like he/she is in pain
    b) Change in activity, appetite, sleep, affect, mobility, depression

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate to addiction.

Definitions Pertaining to Pain, *continued*

Pseudo-addiction is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.

Substance Abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

Source: Kansas State Board of Healing Arts, October 17, 1998.

Condition-specific pain

- Amputee/phantom limb pain
- Burn pain
- Cancer pain
- Headache pain
- HIV-related pain
- Musculo-Skeletal pain (Somatic)
  ~ Described as dull, achy sensation
  ~ Arthritis pain, Osteoarthritis (OA), Rheumatoid Arthritis (RA)
  ~ Ehlers-Danlos Syndrome pain, Low-back pain
- Neuropathic pain
  ~ Described as burning, shooting, lancing, “on fire,” electric-like
  ~ Diabetic Neuropathy pain, Fibromyalgia pain
  ~ Multiple Sclerosis pain, Reflex Sympathetic Dystrophy Syndrome (RSDS)/ Complex Regional Pain Syndrome (CRPS)
- Sickle Cell Disease pain
- Visceral Pain
  ~ Deep organ pain
  ~ Examples: kidney stone pain, gallbladder pain, pulmonary emboli

Source: Kansas LIFE Project Pain Management Advocacy Toolkit

Misconceptions about Pain

Healthcare workers and consumers alike have any number of concerns about aggressive pain management. Administered and monitored properly, pain management is crucial for enhancing quality of life, especially for the elderly.

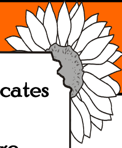
Barriers to pain relief in the elderly (from the Physician/Nurse perspective)

- Pain relief is a low priority for many health professionals
- Relation of analgesia to prognosis
- Fear of opioids - respiratory depression, tolerance
- Fear of addiction (by patient)
- Fear of regulatory scrutiny
- Fear of being duped by patient
- Fear of prescription limits such as quantity, refills, telephone prescribing

Barriers to adequate pain relief in the elderly (from public perspective)

- The myth that pain is a “normal” part of aging
- Fear of addiction to pain medications
- Fear of developing tolerance to pain medications
- The assumption that pain must be endured
- Fear of side effects such as constipation, sedation, respiratory depression, nausea and vomiting
- Fear of bothering staff
- Fear of not being a “good patient”

Source: Person Centered Pain Management Conference



Sensing Pain in Others

Systematic assessment of physical and behavioral symptoms should occur (1) at admission to long-term care, (2) at quarterly reviews, and (3) through daily monitoring and observing behavior. Several types of triggers should elicit monitoring of behaviors:

- Psychotropic use
- Analgesic use
- Select diagnoses
- Change in behavior, affect, environment

Physical Assessment - observe for:

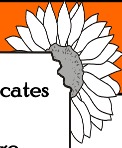
- Poor oral hygiene or dentition
- Pressure points, redness, rashes, lesions
- Increased or decreased breath sounds, crackles, wheezes
- Exercise intolerance
- Decreased urine output, foul smelling urine, fluid retention, ankle edema
- Distention, bowel sounds
- Arthritic conditions, limitation of movement, hesitancy to move a body part, bracing or tenseness of a body part
- Increased confusion
- Recent falls
- Recent medication change

Behavioral Symptoms

The American Geriatrics Society Panel on Chronic Pain in Older Persons (1998) suggests that non-verbal behavior, vocalizations, changes in function, and caregiver reports can be used to assess pain. These are the symptoms of pain in people with dementia, as reported by gerontological nurses, from most frequent to least frequent:

1. Facial grimacing
2. Restless body movement
3. Change in behavior-individualized
4. Moaning
5. Tense muscles
6. Agitation
7. Combative/angry
8. Pull away when touched
9. Changes in mobility/gait
10. Rubbing/holding a body part
11. Crying/tears in eyes
12. Decreased sleep
13. Increased confusion
14. Decreased appetite
15. Family reports
16. Increased sleep
17. Nonspecific verbalizations
18. Exiting behavior
19. Withdraw/become quiet
20. Specific verbal confirmation of pain
21. Change in respiration

Source: Pain Management in the Nursing Home, p. 2.



Initial Assessment Tools

Pain intensity may be difficult to assess, especially when a resident has cognitive impairment. Sometimes using different tools such as the following scales, can be helpful in effectively recognizing, and getting attention to the resident's pain.

Numeric Pain Intensity Scale

The typical numeric scale to gauge pain is from 0 to 10, with 0 being no pain, and 10 being very severe, intolerable level of pain. The scale below explains the numbers.

Mankoski Pain Scale

0	Pain Free	No medication needed
1	Very minor annoyance-occasional minor twinges	No medication needed
2	Minor annoyance-occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective. (Aspirin, Ibuprofen)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3 to 4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3 to 4 hours
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities	Stronger painkillers (Codeine, Vicodin) reduce pain for 3 to 4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycontin, Morphine)
8	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 to 4 hours.
9	Unable to speak. Crying out or moaning uncontrollably - near delirium.	Strongest painkillers are only partially effective
10	Unconscious. Pain makes you pass out.	Strongest painkillers are only partially effective.

Source: www.valis.com/andi/painscale

Initial Assessment Tools, *continued*

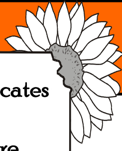
Faces: Wong-Baker FACES Pain Rating Scale

Assessment for Discomfort in Dementia (ADD)

Behavioral Symptoms:

- **Facial Expression** - Grimacing, frowning, blinking, tightly closed or widely open eyes, frightened, weepy, worried, lost
- **Mood -** Irritability, confusion, withdrawal, agitation, aggressiveness
- **Body Language** - Tense, wringing hands, clenched fists, restless, rubbing/ holding body part, hyper or hypoactive, guarding body part, wandering, elopement behaviors, physically abusive, socially inappropriate or disruptive, resists cares, noisy breathing
- **Voice** - Moaning, mumbling, chanting, grunting, whining, calling out, screaming, crying, verbally abusive
- **Behavior** - change in appetite, sleep, mobility, gait, function, participation

Sources: Pain Management Guide, p. 5, and Person Centered Pain Management, Simpson and Twillman.



Initial Assessment Tools, *continued*

The WILDA Tool ~ Words, Intensity, Location, Duration, and Aggravating/alleviating factors

Words *(Have resident provide description; avoid providing words to resident.)*

__ Aching	__ Throbbing	__ Shooting
__ Stabbing	__ Gnawing	__ Sharp
__ Tender	__ Burning	__ Exhausting
__ Tingling	__ Penetrating	__ Nagging
__ Deep	__ Numb	__ Miserable
__ Unbearable	__ Dull	__ Radiating

Intensity of the pain *(0 - 10 scale number or Wong Baker faces number)*

Location of the pain
- Specific or generalized?
- Radiating?

Duration of the pain?
- Constant or intermittent?
- New, recent, or long-term?

Aggravating/Alleviating Factors (such as: time of day, movement, position, use of heat or cold, medications, or massage)
- What makes the pain worse?
- What relieves the pain?

Source: Person Centered Pain Management, Simpson and Twillman.

Initial Assessment Tools, *continued*

The FLACC Tool: Behavior Pain Scale

FLACC incorporates five categories: **F**ace, **L**egs, **A**ctivity, **C**ry and "**C**onsolability". Behavioral scores are viewed with psychological & environmental factors.
(From The University of Michigan Health System-can be reproduced for clinical and research use.)

	-0-	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Able to Console	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult of console or comfort

Source: Pain Management Resource Manual for Long-Term Care Organizations

Non-Pharmacological Interventions

Non-pharmacological comfort measures are essential interventions for treating both physical pain and affective discomfort. Aides and other staff/ caregivers should notify a nurse if these interventions are not in the care plan, but should be considered for the care plan.

- Distraction: Reduce the person's discomfort by focusing attention onto another stimulus. An example of distraction is television watching or music listening.
- Relaxation: Help relieve pain by interrupting the pain-stress-pain cycle in which pain and stress reinforce one another. Relaxation may also be used to treat affective discomfort.
- Massage: This may provide distraction, relaxation, and increase superficial circulation. Massage is also a form of meaningful human interaction.
- Cold: This is hypothesized to relieve pain by causing vasoconstriction, decreasing conduction velocity along nerves, decreasing cell metabolism, and decreasing swelling.
- Heat: Relieve pain by increasing blood flow to the area, improving tissue nutrition and metabolism, reducing muscle spasm, and inducing relaxation. Heat should always be used with great care to avoid burns.

Non-Pharmacological Interventions, *continued*

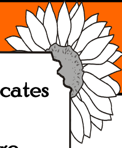
- Movement/Positioning: Exercise may improve circulation, relieve stiffness in arthritic joints, and provide an improved sense of well-being. Helping the person who has a need for movement to ambulate safely is important. Glider rockers can provide movement for people with dementia who are no longer ambulatory. Excessive hand activity needs may be met with rummage boxes, handballs, bean bags, or other safe and interesting tactile stimulation. Because people with dementia may be hyper-oral and have impaired judgment, be sure all items used are safe. Position the person for comfort and good body alignment. Bath blankets may be used to nestle the person in bed or in a geri-chair.

- Sensory stimulation: These interventions are essential components of the treatment plan for people with dementia. Examples of sensory stimulating activities are: pet therapy, music therapy, bread baking, coffee club, gardening, tasting party, folding baby clothes that are warm from the dryer.

- Normalization Activities: Help restore a sense of purpose; incorporate "work" based activities into the person's day. Activities should be geared to the person's ability level. Examples of normalization activities are: flower arranging, cooking, folding laundry, scrubbing vegetables, and afternoon tea.

- Cognitive: Allow the person the ability to communicate stories, emotions, and attitudes through activities such as reminiscence, poetry readings, and friendly visiting.

Source: Person Centered Pain Management Conference manual, Bloom, Nichols, Pimple, Fell, Pelch.



Pharmacological Interventions

Adult Care Home Administrator Practice Guideline
Guidelines for Notifying Physicians of Clinical Problems (1998)

This guideline was developed as a cooperative effort between representatives from the adult care home industry and the Kansas Department of Health and Environment. Facilities may adopt, amend or choose not to use this document. The document is to be considered to be information, not a regulatory requirement.

KAR 28-39-147(g)(1) and 42 CFR 483.10(b)(11) require that the resident's physician be notified whenever there is: an accident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's condition; or a need to alter treatment significantly.

Notification Process

Assessment
1. Licensed nurses have the responsibility of contacting a physician any time they believe a resident has developed a clinical problem which requires physician intervention.
2. An assessment must be performed by the licensed nurse prior to contacting the physician. The following information should be available and provided to the physician as appropriate.
   - ~ Vital Signs
   - ~ Findings from a complete or focused head to toe assessment
   - ~ Current mental status and whether this is a change
   - ~ Current diagnoses
   - ~ Allergies to medications, foods, etc.
   - ~ Current medications
   - ~ Relevant laboratory work/diagnostic studies
   - ~ Actions already taken
   - ~ Presence of advance directives

Planning
1. Before the physician or designee is contacted, the nurse should:
   - ~ Gather and organize information concerning the resident
   - ~ Save non-immediate items for one call and coordinate calls to a physician with other nurses
   - ~ Anticipate questions the physician may ask and have appropriate information available to provide the answers
2. If the physician must return your call, be available when the call is returned or provide an alternate nurse with the information to be relayed to the physician.

Pharmacological Interventions, *continued*

Implementation

1. Attempts to notify a physician should take place in the following order:
   - ~ Attending physician
   - ~ Attending physician's designated alternate
   - ~ Medical Director
2. In situations requiring immediate action, contact emergency medical services to request immediate transport to a hospital. Notify attending physician of the transport as soon as possible.
3. The nurse contacting the physician should provide the physician with their name, the name of the facility and the name of the resident. If the physician is an on-call physician, identify the resident's attending physician.
4. Inform the physician of services available in the facility, or available via mobile units.
5. The resident's legal representative or interested family member should be notified of a significant change in the resident's status unless the resident has specified otherwise.
6. Outcome evaluation. Monitor and reassess the resident's status and response to interventions. Physician should develop a working diagnosis and guide nursing staff in what to expect, what to monitor, and when to re-contact the physician if the resident's progress deviates from the anticipated or expected course.

Documentation

1. Document the following in the resident's clinical record:
   - ~ Document assessment findings
   - ~ All attempts to contact the physician
   - ~ All attempts to notify the family/legal representative
   - ~ Information provided to the physician
   - ~ Physician's response
   - ~ Physician orders
   - ~ Resident status and response
   - ~ Information provided to legal representative/interested family, and their response
2. If the resident remains in the facility, determine if a significant change in condition has occurred. Perform MDS reassessment and amend the care plan as needed.
3. If the physician orders a transfer to another health care facility, complete a transfer form. Send a copy of the most recent history and physical, progress notes, advance directives, list of current medications, relevant laboratory results and X-ray reports.
4. Provide any additional information which will facilitate continuity of care.

Source: Pain Management Resource Manual, pp. 33-35.

About Kansas Advocates

Founded in 1975 as *Kansans for Improvement of Nursing Homes (KINH)*, Kansas Advocates for Better Care continues to be the only statewide consumer-based non-profit organization working to improve the *quality* of long-term care in Kansas.

This 501(c)(3) organization is supported entirely by membership dues, contributions, sales from consumer information products, and grants for special projects. Members and contributors receive newsletters with news about licensed adult care homes throughout Kansas. The volunteer Board of Directors includes consumers, health care providers and business leaders from across the state.

Contact information:
913 Tennessee, Suite 2 Lawrence, Kansas 66044
Phone 800-525-1782
Email info@kabc.org
Website: www.kabc.org