15th Annual
Life Star of Kansas
Emergency Care Symposium
September 19, 2017
Symposium Faculty:

Daniel A. Batsie, EMT-P
Emergency Medical Services Chief, Vermont Department of Health, Burlington, VT

Rob Bryant, MD
Board Certified Emergency Physician, Utah Emergency Physicians, Salt Lake City, UT
Adjunct Assistant Professor (Clinical), Division of Emergency Medicine, Department of Surgery, University of Utah School of Medicine.
Advanced Practice Clinician Supervising Physician, Utah Emergency Physicians

David W. Seastrom, RN, BSN
Trauma Injury Prevention/Outreach/Education Coordinator,
Children’s Mercy Kansas City. Level I Pediatric Trauma Center, Kansas City, MO

Michelle W. Schierling, MD
Board Certified Emergency Physician, Stormont Vail Health,
Topeka, KS
Medical Staff President, Stormont Vail Health, Topeka, KS
Medical Director, Life Star of Kansas, Topeka, KS

Kevin Callopy, EMT-P
Clinical Outcomes Manager, AirLink/VitaLink, Wilmington, NC
Education Objectives

Describe injury patterns consistent with child abuse or neglect

Describe recent changes/advances in adult intra and post arrest care

Describe the evidence behind applying changes in adult cardiac arrest care to pediatric arrests

Discuss benefits of Ketamine: Analgesia, agitation control, antidepressant

Discuss downsides to Ketamine use: emergence, transient hypertension

Describe the possible risk associated with cervical collars and back boards

Describe three improvements to training that can help inoculate providers against critical stress

Describe the best practice assessment and treatment for tension pneumothorax, rib fractures, flail chest and pulmonary contusions

Discuss the significance of rural trauma

Highlight opportunities for the improvement in rural trauma care

Understand the pathophysiology of sepsis and core immune system concepts

Explain the current diagnostic criteria and treatment guidelines for sepsis
Schedule
Tuesday, September 19, 2017
Great Lakes Ballroom

0715-0745  Registration *(Continental Breakfast Provided)*

0745-0800  Announcements

0800-0900  **Fear Factor 10: How Stress Impacts Critical Decisions and Performance**
Daniel A. Batsie, EMT-P

0900-1000  **Pediatric Intra and Post Arrest Management: If It Works for Otto, Will It Work for Bart?**
Rob Bryant, MD

1000-1015  **Break**

1015-1100  **As the Pressure Rises: Life Star Case Studies**
Michelle W. Schierling, MD

1100-1200  **Case Studies in Trauma Care**
Kevin Collopy

1200-1300  **Lunch provided**

1300-1400  **Diagnosing and Treating Sepsis and Septic Shock**
Kevin Callopy

1400-1430  **Ketamine: Too Good To Be True?**
Rob Bryant, MD

1430-1500  **The New Spine Revolution: Review of C-Spine and Backboard Utility**
Rob Bryant, MD

1500-1515  **Break**

1515-1615  **Rethinking our Emergent Approach to Chest Injuries**
Daniel A. Batsie, EMT-P

1615-1715  **Child Abuse-The Dark Side of Pediatrics**
David W. Seastrom, RN, BSN

1715  Adjourn
Professional Credit/Accreditation

Provided by Stormont Vail Health

EMS
Stormont Vail Health is an approved program provider by the Board of Emergency Medical Services and has approved this program for 9.3 contact hours for EMS re-licensure. Identification number: PP-6107.

Nursing
Stormont Vail Health is approved as a provider of continuing nursing education by the Kansas State Board of Nursing. This course offering is approved for 9.3 contact hours and is applicable for APRN, RN and LPN re-licensure. Kansas State Board of Nursing Approved Provider Number is LT0072-0538.

RT
Stormont Vail Health CEU Evaluator has approved this program for 9.3 hours of Respiratory Continuing Education on behalf of the Kansas Respiratory Care Society, a chapter society of the AARC. Providership #KRCS 027.

Physician
This activity has been planned and implemented in accordance with the Accreditation Requirements and Policies of the Kansas Medical Society through the joint providership of Stormont Vail Medical Education Services and Life Star of Kansas. Stormont Vail Medical Education Services is accredited by the Kansas Medical Society to provide continuing medical education for physicians. Stormont Vail Medical Education Services designates this live activity for a maximum of 8.0 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
Speaker Bio’s

Daniel A. Batsie, EMT-P
Dan Batsie has been involved in emergency medical services for over 25 years. He began his career as a paramedic in Syracuse, NY and later as a paramedic firefighter in Portland, Maine. He has been an EMS educator since 1994 and is currently the Education Director for Atlantic Partners EMS in Bangor, Maine. He serves as department chair of Emergency Medical Services at Eastern Maine Community College and is an adjunct faculty member in the Kennebec Valley Community College Paramedic Program. Dan is also the author of two EMS textbooks, a contributing author for several other EMS texts and has published numerous journal articles.

Short Bio
Dan Batsie has been involved in emergency medical services for over 25 years and has been an EMS educator since 1994. He is currently the Education Director for Atlantic Partners EMS in Bangor, Maine and serves as department chair of Emergency Medical Services at Eastern Maine Community College. Dan is also the author of two EMS textbooks, a contributing author for several other EMS texts and has published numerous journal articles.

Rob Bryant, MD
Bob graduated from The University of Otago School of Medicine, New Zealand, in 1998, and completed his Emergency Medicine residency at the Medical College of Wisconsin in 2004. He flew for Flight for Life in residency. He writes for the REBELem.com blog, and produces quarterly educational content for Classic Air Medical. His clinical interests include ED critical care, simulation, and education.

His extra curricular interests include cross country skiing, mountain biking, and trail running.
David Seastrom RN, BSN

David Seastrom is the Outreach & Education Coordinator for Trauma & Burn Services at Children’s Mercy in Kansas City. David attended Kansas State University followed by Baker University School of Nursing. David was an Emergency Medical Technician Intermediate for 7 years and a registered nurse for the past 15 years with experience in pre-hospital, emergency & flight medicine. He also has experience in critical care transport and trauma program management in both adult and pediatric trauma centers. In addition, David promotes educational development and training with special interest in trauma center development, resuscitation and pediatric trauma.

Michelle Schieling, MD

Dr Schierling is a native Kansan who spent the first few years of her medical career working as a physician assistant in Hiawatha Kansas. She graduated medical school from University of Kansas in 2004 and completed her emergency medicine residency at Vanderbilt University in 2008. Michelle and her husband moved back to Kansas and joined Stormont Vail in 2009. Michelle has served as medical director of the emergency department, emergency department chair and most recently as medical staff president. In addition to her duties as emergency physician, Dr Schierling and her husband run a three ring circus they call home which includes her three children Anna, Luke and Elizabeth, two dogs, two cats and five chickens. Dr Schierling’s latest adventure has been as the medical director of Lifestar which she began in January of this year.
“Fear Factor 10: How Stress Impacts Critical Decisions and Performance”

Daniel A. Batsie, EMT-P
“Pediatric Intra and Post Arrest Management: If It Works for Otto, Will It Work for Bart?”

Rob Bryant, MD
Pediatric CPR and Post Arrest Care

‘If it works for Otto, will it work for Bart?’
Rob Bryant MD, robjbryant13@gmail.com

PEDIATRIC ARREST DATA:

1. Survival after Out of Hospital Cardiac Arrest in Children
   J Am Heart Assoc. 2015; 4
   PMID: 26450118

   2005-2013, review of 1980 pediatric out of hospital cardiac arrests
   88.4% arrested at home
   90% with non shockable rhythm
   21.7% Infant   (0-1)
   48.1% Young Children  (2-7)
   13.9% Older children (8-12)
   16.3% Teenager    (13-17)

   Survival to discharge 8.2%
   There was no improvement in survival from 2005 to 2013.

   The problem:
   ‘Successful CPR requires the rapid and effective implementation of infrequently used
   skills, in tense, high stakes situations.’

   INTRA-ARREST:

   EPINEPHRINE:

   Adult studies show no overall survival benefit with standard, or high dose epinephrine during cardiac arrest. There is
   an increased rate of return of spontaneous circulation, and survival to 24h hours. There is NOT an increased rate of
   survival neurologically intact to discharge.

   2. Adrenaline for out of hospital cardiac arrest resuscitation: A systematic review and meta-analysis of
      PMID: 24642404
      14 studies are reviewed, (12,246 patients).
      Epinephrine vs placebo, standard dose vs high dose epinephrine, standard dose epinephrine vs epinephrine and vaso-
      pressin, and standard dose epinephrine vs vasopressin.
      Studies with higher doses of epinephrine improved ROSC, and survival to admission, but not survival to discharge
      neurologically intact.

   3. Prehospital epinephrine use and survival among patients with out of hospital cardiac arrest. JAMA
      2012 Mar 21;307(11):1161-8
      PMID: 22436956
      417,188 patients. Observational study (in Japan providers need to call medical control to give epinephrine). 15,030
      received epinephrine, 402,158 did not.
Guidelines are softening:

2010 AHA guidelines:
It is reasonable to consider epinephrine every 3-5 minutes.

2015 AHA Guidelines:
Standard dose epinephrine may be reasonable for patients in cardiac arrest.

2015 PALS:
There are no pediatric studies showing effectiveness of any vasopressors in cardiac arrest.

4. Time to Epinephrine and survival after pediatric in hospital cardiac arrest.
JAMA 2015;314(8):802-810
PMID: 26305650
1558 pediatric patients, in hospital arrest, non shockable rhythms.
67% ROSC
47.8% Alive at 24 hours
31% survival to discharge with 15.6% favorable status
A delay in time to epinephrine administration was associated with decreased ROSC, 24 hour survival, and survival with good neurological function.
Each 1 minute delay in the administration of epinephrine:
ROSC 0.97
24h Survival 0.97
Survival with good neuro outcome 0.97
(adjusted relative risk per minute delay)

2015 AHA Guidelines:
‘It is reasonable to administer epinephrine in pediatric arrest’
Class II evidence.

DRY CODES?:

Some providers run ‘dry codes’ in adults where no medications are given. The benefit is a decrease in task saturation, allowing better focus on compressions, and timing of defibrillation, along with less ‘unnecessary ROSC’ where short term survival is achieved without a good long term outcome.

EPINEPRINE DRIP INSTEAD OF BOLUSES:

The use of an epinephrine drip can potentially allow continued administration of epinephrine in either code doses, or more reasonable physiologic doses. Having a drip running allows for some cognitive offload, and can shift the focus toward better compressions.
The epinephrine drip can also mitigate any post ROSC hypotension. In some cases after ROSC has been achieved following the use of ‘code dose epinephrine’ it can be followed by a precipitous drop in BP. Having a titratable epinephrine drip running can mitigate this.
The CHEER trial evaluating the use of extracorporeal membrane oxygenation during cardiac arrest used an epinephrine drip at 0.5 mcg/kg/min for their patients while they were cannulating patients for intra-arrest ECMO.

5. Refractory cardiac arrest treated with mechanical CPR, hypothermia, ECMO and early reperfusion
Standard care versus intra-arrest ECMO for adult out of hospital cardiac arrest patients. While cannulating patients for ECMO during CPR an epinephrine drip was started at 0.5 mcg/kg/min, instead of using bolus / code doses of epinephrine.

0.5 mcg/kg/min equates to 250 mcg every 5 minutes, which is 25% of the epinephrine dose a 100kg patient would receive during a cardiac arrest.

**PEDIATRIC INTRA-ARREST EPINEPHRINE DRIP DOSING:**

A 20kg patient would receive 0.01mg/kg during a cardiac arrest.
This is 0.2mg every 5 minutes. (40 mcg / min)
The equivalent drip rate would be 40 mcg/min, or 2 mcg/kg/min

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**CPR:**

**CCR: Cardio Cerebral Resuscitation.**

Concept of optimizing compressions, and minimizing all other interruptions in the first few minutes of a cardiac arrest.
Immediate CPR
No Post shock rhythm or pulse checks
No airway interventions other than a non rebreather and oral airway.
In a witnessed arrest, there were no assisted ventilations or intubation attempts until ROSC or 3 cycles of CPR had been completed.

PMID: 16564776
Before :after comparison of cardiac arrest survival after introduction of CCR.
In patients with shockable rhythms neuro intact survival improved from 15% to 48%

PMID: 19414637
Before : After comparison.
Limited CPR interruption, increased compression to ventilation ratio.
De-emphasizing / delaying intubation.
Delivered compressions before first shock.
In arrest of presumed cardiac cause survival improved from 7.5% to 13.9%
In patients with shockable rhythms ROSC improved from 37.8% to 59.6%

Pediatric arrests are more likely to be due to respiratory compromise, so delaying airway interventions may not work in this setting.
PALS algorithm goes through 1 -2 cycles of CPR prior to suggesting ‘consider advanced airway’.
CCR approach provides continued attention to quality, minimally interrupted compressions.

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**PERI-SHOCK PAUSE:**

Most pediatric arrests will not have shockable rhythms. If there is a shockable rhythm we need to be aware of issues surrounding the peri-shock pause.
Peri-shock pause is the total time without chest compressions while a shock is delivered. It includes the pre-shock pause, and the post shock pause.

8. The impact of peri-shock pause on survival from out of hospital shockable cardiac arrest during the Resuscitation Outcomes Consortium PRIMED trial. 
Resus. 2014 Mar;85(3):336-42 
PMID: 24513129
2006 patients with shockable rhythms
Median pre-shock pause 15 seconds
Median post-shock pause 6 seconds
Median peri-shock pause 22 seconds

Odds of survival to Discharge IMPROVE with a shorter pre, and peri-shock pause.
Pre shock pause <10 seconds, vs >20 seconds: 1.52
Peri-shock pause <20 seconds, vs >40 seconds: 1.82
No difference with post shock pause length.

PEDIATRIC IMPLICATIONS:
There will be fewer opportunities for shock delivery in pediatric arrests, however applying this strategy of minimizing CPR interruptions to other interventions such as intubation is likely to improve outcomes.
‘If you cannot intubate without stopping compressions, learn how!’

CPR QUALITY:

PMID: 20226582
42 subjects performed 4 different cycles of CPR (2 min per cycle)
Assessed for rate, depth.
Average rate: 110 / min
High quality compression rate (based on depth) 9.4%

END TIDAL CO2:

‘ETCO2 is the smoke that rises of the metabolic fire.’ Ray Fowles, MD

PMID: 24732917
2kg pigs, 20 per group.
Group one: Optimized CPR
Real time video feedback for rate, depth, with verbal and visual prompts.
Group two: ETCO2 based CPR
Only visible metric was ETCO2 value.
ROSC rates were statistically similar (65% vs 70%) with higher ETCO2 levels in the ETCO2 group (28.5 vs 22.7) and higher MAP’s in the ETCO2 group.

2015 AHA Guidelines:
ETCO2 monitoring may be considered to evaluate quality of chest compressions.
Specific values to guide therapy have not been established.
A goal of >15mmHg is reasonable.

**PULSE CHECKS:**

PMID: 9715777
Healthy 30 year old male volunteer.
ICU and ED staff were timed to locate carotid pulse.
43% took longer than 5 seconds, 4% took longer than 10 seconds.

PMID: 9025126
Timed first responders to assess for the presence of a carotid pulse in a patient undergoing coronary artery bypass surgery.
Pulses were assessed during spontaneous circulation, and during non pulsatile cardiopulmonary bypass.
BLS trained laypersons vs EMT’s vs Paramedics.
10% did not recognize pulselessness
45% did not recognize pulse with a BP of 80 mmHg
2% identified pulselessness in <10 sec
15% produced correct diagnosis in <10 sec

PMID: 18992985
Pediatric ECMO / LV AD patients at various stages of recovery.
209 ICU MD’s and RN’s assessed presence of pulse in patients on LVAD’s or VA ECMO.
Overall accuracy 78%
CPR inappropriately withheld: 14%
CPR inappropriately given: 36%

**END TIDAL CO2 TO ASSESS FOR ROSC:**

A large bump in ETCO2 can signify an increase in cardiac output, and suggest ROSC.

PMID: 19570645
108 patients with cardiac arrest and continuous ETCO2 monitoring. Age 0.5 – 90 years.
59 with ROSC, 49 without ROSC.
ETCO2 pre vs post ROSC: 26.65 vs 36.60 mmHg
STOPPING CPR:

There are no good guidelines.

NEJM 1997, 337(5) 301-6 
PMID: 9233867 
150 consecutive cardiac arrests. 
When ETCO2 is < 10 mmHg at 20 min, likelihood of neuro-intact survival is extremely low. 
ETCO2 < 10 mmHg at 20 min + non survivable 
Sens, Spec, Positive predictive value, Negative predictive value all 100% 

RULE OF 10’s: 
Bump of 10 mmHg: ROSC 
ETCO2 > 10 mmHg at 20 min: stop. 

2015 AHA Guidelines: 
No significant factor predicts outcome with significant accuracy to recommend termination. 
Age <1 
In Hospital arrest 
Non shockable rhythm 

POST ARREST CARE: 

TARGETTED TEMPERATURE MANAGEMENT: 

16. Mild therapeutic hypothermia to improve the neurologic outcome after cardiac arrest.(HACA) 
NEJM 2002 Feb 21;346(8):549-56 
PMID: 11856793 
273 Patients, 33C vs usual care. 
41% vs 55% mortality NNT 7 

17. Treatment of comatose survivors of out of hospital cardiac arrest with induced hypothermia.(Bernard) 
NEJM 2002 Feb 21;346(8):557-63 
PMID: 11856794 
77 patients. 33C vs usual care 
49% vs 26% favourable outcome. NNT 4.5 

Combined NNT 6 

18. Targeted temperature management at 33 C versus 36 C after cardiac arrest. 
NEJM 2013, dec 5;369(23):2197-206 
PMID: 24237006 
33C vs 36C 
973 patients. 
48% vs 50% mortality 
Fever avoidance is the current standard, with some centers staying with 33C.
NEJM 372;20 May 14, 2015 1898-908
PMID: 25913022
260 patients
CPR >2min, unconscious post ROSC
33C vs 36.8C (therapeutic normothermia)
No difference in 12 month survival with VABS-II > 70
Recommendations:
Avoid fever

OXYGEN:

Hyperoxia may be harmful in the post arrest setting.

20. Relationship between supranormal oxygen tension and outcome after resuscitation from cardiac arrest. Circulation 2011; 123: 2717-2722
PMID: 21606393
4459 patients
54% mortality
Dose dependent association between supra-normal oxygen tension and in-hospital death.
Every 100 mmHg increase in PaO2 associated with 24% increased risk of death.

RECOMMENDATION:
HAVE A MEASURABLE O2 SAT (94-99%) NOT 100%

PEDIATRIC POST ARREST OXYGEN LEVELS:

PALS recommends PaO2 >60 and <300mmHg

PMID: 22723307
Severe hypoxia, and to a lesser extent, hyperoxia are associated with an increased risk of death after PICU admission after cardiac arrest.
PaO2 >600mmHg gives an OR of 1.25 (1.17-1.37) for Death.

22. High cumulative oxygen levels associated with improved survival of children treated with therapeutic hypothermia after cardiac arrest.
Resuscitation 2015 (90) 150-157
PMID: 25576438
200 patients, aged >28 days, mean 2.6 years.
ABG at 3 time intervals, and 3 cut-off values
42% survival to discharge, 29% managed with TTM
Higher cumulative PaO2 level associated with lower in hospital mortality.
POST ARREST BP GOALS:

Adults:
AHA Guidelines
MAP >65mmHg
SBP >90mmHg
(some authors suggest MAP>75mmHg)

Pediatric BP goals:
2015 AHA guidelines
NO studies looking at specific post ROSC pressor.
Fluids +/- Pressors for goal SBP >5th percentile

23. Early post resuscitation hypotension is associated with increased mortality following pediatric cardiac arrest.
Critical Care Med. 2014;42:1518-23
PMID: 24561563
Increased risk of death for SBP <5th percentile post ROSC (53% vs 41%)
Increased odds of in-hospital death: 1.71 (95% CI: 1.02-2.89 p=0.042)

PUSH DOSE PRESSORS:

Push dose pressors are an easy way to give a small dose of a known, and safe concentration of epinephrine.
'A transient fix for hypotension, and a fix for transient hypotension’
Useful as a bridge to a pressor drip, or to have available in the event of peri-intubation hypotension.
See www.emcrit.org/pushdosepressors for more details.
1cc of 1:10,000 (code cart epi) in 9cc saline.
Makes 10 mcg/ml concentration. 1:100,000.
This is the same concentration of epi as is in Lidocaine with epi, so there is no concern for extravasation from a peripheral iv.
Dosing:
80kg male who would require a high dose epi drip (0.5 mcg/kg/min) would receive 40 mcg /min. This is 4 cc of push dose epi (10mcg/ml)
10 kg patient requiring a 0.5 mcg/kg/min drip would require 5 mcg per min. This would be 0.5 cc of push dose epi per minute.

PRESSOR CHOICE:

Pressor selection in adults is relatively easy, as regardless of the type of pressor-responsive shock (cardiogenic, distributive, spinal) Norepinephrine is the pressor of choice.
Historically dopamine has been the ‘goto’ agent for an easy pressor to start through a peripheral iv in both adults, and children.

PMID: 26323041
Septic shock cohort: 1 month to 15 year old children with fluid refractory septic shock.
28 day mortality:
Dopamine: 20.6%
Epinephrine: 7%

Recommendation: Use epinephrine drip for any sick kid.

**INTERVENTIONS THAT HELP:**

ETCO2 for compression quality, evidence of ROSC, and justification for termination
Compressions
Epinephrine
Post ROSC fever avoidance

**INTERVENTIONS THAT DO NOT HELP:**

Pulse checks
Peri-shock pauses (and stopping compressions to intubate)
Dopamine
Hyper-Hyperoxia

**EXTRA 10 MINUTES IN THE ROOM:**

Sara Gray MD (@emicucanada) gave a great talk at the SMACC conference in June 2015. She recommended spending an extra 10 minutes in the room after ROSC, and after any intubation to ‘sweat the small stuff’
Ensure the ETT is at the right depth, check the cuff, re-check the vent settings, dial down the FiO2, check the ETCO2, ensure appropriate post intubation analgesia and sedation, recheck lines and drips.

‘it doesn’t matter how good you are at doing the fancy stuff, if you are not EXCELLENT at doing the easy stuff!’
“Tales from 3000 feet: Life Star Case Studies”

Michelle W. Schierling, MD
“Case Studies in Trauma Care”

Kevin Collopy, EMT-P
“Diagnosing and Treating Sepsis and Septic Shock”

Kevin Collopy, EMT-P
DIAGNOSING AND TREATING SEPSIS

Objectives

1. Understand the pathophysiology of sepsis and core immune system concepts

2. Describe the history of the surviving sepsis campaign

3. Use core measures and indicators, such as lactate, to improve outcomes

4. Describe the pearls and pitfalls or using lactate measurement, as well as alternatives

5. Explain the current diagnostic criteria and treatment guidelines for sepsis
“Ketamine: Too Good To Be True?”

Rob Bryant, MD
KETAMINE, TOO GOOD TO BE TRUE?

Objectives

1. Discuss the additional benefits of Ketamine: Analgesia, Agitation control, Antidepressant

2. Discuss the downsides to ketamine use: emergence, transient hypertension

3. Discuss the need for dose adjustment when using ketamine in the critically ill

Rob Bryant, MD
THE NEW SPINE REVOLUTION

Objectives

1. Describe the historical use of Cervical spine immobilization

2. Describe the possible risk associated with Cervical Collars

3. Describe the historical use of back boards

4. Describe the possible risk associated with Backboards
“Rethinking our Emergent Approach to Chest Injuries”

Daniel A. Batsie, EMT-P
“Child Abuse- The Dark Side of Pediatrics”

David W. Seastrom, RN, BSN
Objectives

This lecture will bring you face-to-face with one of the most challenging patients they will care for. Whether it’s a rural environment or the booming metropolis children who suffer child abuse are at a higher risk of injury and even death if not recognized promptly. This lecture aims to aid you in feeling more comfortable caring for children who have suffered abuse and to know exactly what to look for.

- Describe injury patterns consistent with child abuse or neglect

- List factors that put a child at a higher risk of abuse
Important Information

Evaluation & Certificate

Stormont Vail Health
CloudCME App:
1. Download CloudCME™ from your App Store.

2. Organization Code is ‘stormontvail’, log in with email and CloudCME password (we can reset it for you). Presentations from today are under Syllabus (green bar).

Evaluation/Certificate of Attendance:
1. Login to CloudCME from your computer: https://stormontvail.cloud-cme.com

2. Click on Evaluations & Certificates, click on Complete Evaluation. Make sure all RED fields are complete.
**Presentation/Handouts:**

1. Click on the Syllabus tab to see a list of conferences you have attended with syllabus availability.

2. Click on the Syllabus button to view/download a PDF of the presentation(s).
Thank you for attending!
SAVE THE DATE

Prairie Band Casino and Resort

Mayetta, Kansas

SEPTEMBER

18th

2018
Life Star of Kansas
6520 SE Forbes Ave
Topeka, Kansas 66619

visit our website:
www.kslifestar.org