This report is not policy. These resolutions will not become Academy policy until formally acted upon by the House of Delegates.

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*Shaded resolutions were Adopted on the General Consent Agenda and will not appear in this document.
Mister Speaker, the Reference Committee on Education, Constituencies, Professional Practice, Government Affairs, and Public Policy has considered each of the resolutions referred to it and wishes to present the following report. The committee's recommendations on each extracted resolution will be submitted separately, and I respectfully suggest that each extracted item be dealt with before going on to the next. Mr. Speaker, please proceed with the extraction process.

The Committee considered testimony on 2013-B-01, the resolved portion of which reads:

Amend policy HX-4400.2.2 as follows:

AAPA supports handgun control legislation and other legislation that effectively reduces the criminal ownership and use of handguns, as well as:

- BANNING ASSAULT TYPE WEAPONS,
- BANNING HIGH CAPACITY AMMUNITION MAGAZINES AVAILABILITY TO THE GENERAL POPULATION,
- LIMITING THE TOTAL NUMBER OF AMMUNITION FOR PURCHASE WITHIN A SPECIFIED TIME PERIOD,
- ESTABLISHING A DATABASE OF GUN PURCHASES AND REQUIRING BACKGROUND CHECKS FOR ALL GUN PURCHASES,
- CLOSING THE “PRIVATE GUN SHOW” LOOPHOLES ALLOWING SALES OF ALL TYPES OF WEAPONS TO ANYONE,
- MANDATING RECORD OF ALL SALES MADE AND REQUIRING BACKGROUND CHECKS,
- STRICT ENFORCEMENT OF EXISTING GUN CONTROL LAWS,
- PHYSICIAN ASSISTANTS BEING INCLUDED IN THOSE CAPABLE AND REQUIRED (NYS POLICY, 2013) TO REPORT TO GUN CONTROL ENFORCEMENT AGENCIES PERSONS IN THEIR CARE EXHIBITING BEHAVIOR DANGEROUS TO THEMSELVES OR OTHERS MAKING THEM UNFIT TO PURCHASE WEAPONS,
- MANDATE STRICT STORAGE REQUIREMENTS FOR IN HOME, RETAIL AND WHOLESALE ESTABLISHMENTS FOR ALL FIREARMS AND INCORPORATE THE USE OF TRIGGER LOCKS FOR ALL WEAPONS.

AAPA supports policies and educational programs that will effectively reduce homicide, suicide, and other violence.

Pro Testimony:
There was considerable pro testimony focused on patient safety and education.
Testimony was given about recent high profile shooting incidents.

Con Testimony:
There was considerable con testimony focused on the constitutional right to bear arms.
There were also concerns the policy reflected a laundry list of topics.
Conflicting Testimony:

There was conflicting testimony regarding the purview of the policy, as well as dividing the issues of gun safety and education vs. gun safety and regulation.

Additionally, as the reference committee evaluated the resolution, there was concern some verbiage was state specific.

Mister Speaker, I move that Resolution 2013-B-01 be referred to the appropriate body for its consideration and that its recommendation on this resolution be submitted by the 2014 House of Delegates.

The Committee next considered testimony on 2013-B-02, the resolved portion of which reads:

The AAPA should be a leader in an initiative to reduce the pervasiveness and glamorization of violence in all forms including gun violence and violence in gaming and the media.

And be it further resolved that AAPA should work with the appropriate work groups and task forces to consolidate the various materials already existing and to develop any necessary new materials to address the increased acceptance of violence in our culture.

This consolidation should be easily found on the AAPA website for members to use in their interactions with patients, families, schools, and communities to spread the message.

There was no con testimony.

Mister Speaker, the committee recommends adoption of Resolution 2013-B-02.

The Committee next considered testimony on 2013-B-05, the resolved portion of which reads:

2013-B-05 Resolved

Amend the position paper entitled Guidelines for State Regulation of Physician Assistants - section on Supervision adding:

FOR PAS WHO PRACTICE IN FEDERAL JURISDICTIONS, SUPERVISION MAY BE PROVIDED BY A PHYSICIAN (MD OR DO) WHO MEETS THE LICENSING REQUIREMENTS OF THE FEDERAL AGENCY. LICENSURE IN THE STATE SHOULD NOT BE REQUIRED FOR FEDERAL SUPERVISING PHYSICIANS, IF IT IS NOT REQUIRED BY THE FEDERAL AGENCY.

No testimony was given on the original language.

A delegate proposed an amendment beginning at line 53 of the position paper to clarify the definition of a physician assistant:
**Definition of Physician Assistant**
The state law must include a definition of physician assistant in order to differentiate PAs from the many others who assist physicians.

After the consideration of the testimony, the committee recommends the following amendment by substitution:

Amend the position paper entitled Guidelines for State Regulation of Physician Assistants - section on Supervision adding:

**(Beginning line 134 as published)**
FOR PAS WHO PRACTICE IN FEDERAL JURISDICTIONS, SUPERVISION MAY BE PROVIDED BY A PHYSICIAN (MD OR DO) WHO MEETS THE LICENSING REQUIREMENTS OF THE FEDERAL AGENCY. LICENSURE IN THE STATE SHOULD NOT BE REQUIRED FOR FEDERAL SUPERVISING PHYSICIANS, IF IT IS NOT REQUIRED BY THE FEDERAL AGENCY.

**(Beginning line 53 as published)**

**Definition of Physician Assistant**
The state law must include a definition of physician assistant in order to differentiate PAs from other healthcare clinicians who provide direct care to patients.

Mister Speaker, I move that Resolution 2013-B-05 be so amended by substitution.

The Committee next considered testimony on 2013-B-10, the resolved portion of which reads:

**Acknowledging and Apologizing for Adverse Outcomes**
(Adopted 2007 and reaffirmed 2012)

**Executive Summary of Policy Contained in this Paper**
Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper

IMPROVING HEALTHCARE QUALITY AND REDUCING PREVENTABLE ADVERSE EVENTS IN CARE DELIVERY CONTINUE TO BE A TOP PRIORITY FOR THE UNITED STATES HEALTH CARE SYSTEM. SINCE THE INSTITUTE OF MEDICINE (IOM) PUBLISHED ITS 1999 REPORT TITLED “TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM,” EMPHASIS AND EFFORT IN REDUCING PREVENTABLE INJURY AND IMPROVING CARE DELIVERY HAVE TAKEN PLACE. FURTHER, THE DISCIPLINE OF DISCLOSURE OF MEDICAL ERROR HAS SEEN SIGNIFICANT ADVANCEMENT.

- AAPA BELIEVES PHYSICIAN ASSISTANTS CAN BE MORE EDUCATED AND INVOLVED IN ADVANCING THE SCIENCE OF DISCLOSING MEDICAL ERRORS IN HEALTH CARE
- AAPA BELIEVES THAT PATIENTS DESERVE COMPLETE AND HONEST EXPLANATIONS OF ADVERSE OUTCOMES AND APOLOGIES FOR MEDICAL MISTAKES
THE AAPA ALSO SUPPORTS NOT ONLY THE CURRENT SCIENCE AROUND DISCLOSURE AND APOLOGY DURING CARE DELIVERY, BUT ALSO ENCOURAGES PHYSICIAN ASSISTANTS TO BE ACTIVE PARTICIPANTS IN LOCAL DISCLOSURE PROGRAMS.

The Institute of Medicine, in its 1999 report, *To Err is Human: Building a Safer Health System*, declared that preventable adverse events are a leading cause of death in the United States. The report estimated that more than one million preventable adverse events occur each year in this country and 44,000 to 98,000 people die in hospitals annually as a result of medical errors. Americans responded to this report by initiating efforts to reduce medical errors. The patient safety movement has focused on redesigning systems, implementing safe practices to prevent accidental injury, and establishing medical error reporting systems. Because the complete elimination of errors in medical treatment, although highly desirable, is an unattainable goal, attention is also being paid to the way institutions and caregivers respond when injuries occur.

**Disclosing Errors**

The IOM has previously reported that as many as 98,000 people die each year as a result of medical error. Adverse outcomes can occur in any health care setting, including inpatient, outpatient, home and long-term care. Further, preventable harm from care delivery impacts not only patients, but families, caregivers, staff and communities.

Health care organizations that establish a culture of quality and safety are more likely to proactively identify a crisis management plan. These plans include processes that enhance communication between and among all stakeholders. Thus, every health care organization should establish a plan to address adverse events. The response should be prioritized to include 1) the patient and family; 2) the frontline staff; and 3) the organizational response (i.e., initiate root cause analysis and crisis management team).

The Joint Commission set new standards in 2001 requiring the disclosure of outcomes of care, including those that were not anticipated, to hospitalized patients and their families. A number of states have passed laws requiring that patients be informed about unanticipated outcomes and many institutions, including the Department of Veterans Affairs, require facilities and providers to disclose adverse events to patients who have been harmed in the course of their care. Disclosure is commonly defined as a prompt, truthful, and compassionate explanation of how the injury occurred, its short- and long-term effects, remedies available to the patient, and steps developed following an analysis of the root cause of the error that will be taken to prevent its recurrence. Errors do not always constitute improper, negligent or unethical behavior, but failure to disclose them may.

**THE PATIENT AND FAMILY**

The patient and family must be the priority of the health care organization and the provider before, during and after an adverse event. Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by many ethicists and professional organizations.
to the “Guidelines for Ethical Conduct for the Physician Assistant Profession,” PAs “should disclose errors to patients if such information is significant to the patient’s interests and well being. AS DISCLOSURE SCIENCE IN HEALTH CARE CONTINUES TO DEVELOP, MUCH OF THE DATA GENERATED HIGHLIGHTS THE FUNDAMENTAL IMPORTANCE OF OPENLY ADMITTING ERROR (4). A NUMBER OF STUDIES SUGGEST THAT BOTH THE PUBLIC AND HEALTH CARE PROFESSIONALS GENERALLY AGREE THAT MEDICAL ERRORS CAUSING HARM SHOULD BE DISCLOSED TO THE PATIENT, AN APOLOGY RENDERED, AND FAIR COMPENSATION BE NEGOTIATED. THIS PROCESS HAS DEMONSTRATED A REDUCTION IN LITIGATION COSTS AND HAS BEEN WIDELY ADOPTED BY HEALTH SYSTEMS BOTH ACADEMIC AND FEDERAL (5).

THE FRONTLINE STAFF

HEALTH CARE STAFF CAN BECOME THE “SECOND VICTIMS’ OF ADVERSE EVENTS (2). THIS MAY OCCUR SECONDARY TO BLAMING BEHAVIORS, DAMAGE TO PERSONAL OR PROFESSIONAL REPUTATION, AND UNRESOLVED FEELINGS OF SORROW AND LOSS (2). ORGANIZATIONS WITH AN EXISTING CRISIS MANAGEMENT PLAN, A SHARED PROCESS OF ROOT CAUSE ANALYSIS AND CULTURE OF INCLUSION PROMOTE PATIENT-CENTERED QUALITY AND SAFETY (2).

THE ORGANIZATIONAL RESPONSE

THE CULTURE OF SAFE AND HIGH-QUALITY HEALTH CARE BEGINS WITH THE ORGANIZATIONAL LEADER, WHO PROACTIVELY DEVELOPS A CRISIS MANAGEMENT PLAN AND ASSUMES SHARED RESPONSIBILITY WHEN ADVERSE EVENTS TAKE PLACE (2). FOLLOWING AN ADVERSE EVENT, IT IS CRITICAL FOR LEADERS TO INCLUDE ALL STAKEHOLDERS IN THE ROOT CAUSE ANALYSIS (2). THIS PROCESS ENHANCES COMMUNICATION, PROMOTES HEALING AND ENSURES LEARNING TAKES PLACE (2). MOST IMPORTANTLY, LEADERSHIP MUST ENSURE THAT THE PATIENT AND FAMILY ARE CLEARLY INFORMED THROUGHOUT THE PROCESS OF THE INVESTIGATION (2).

POLICY AND LEGISLATION

To counter the perceived risk of increased liability, a number of states have adopted or are considering apology laws that exempt expressions of regret, sympathy, or compassion from being considered as admissions of liability in medical malpractice lawsuits (6). Federal legislation has also been drafted that promotes medical error reporting, disclosure to patients, apology, and, in cases when the standard of care is not met, offers of compensation. This legislation is based on the principles of The Sorry Works! Coalition, which believes that full disclosure addresses the root cause of the medical malpractice crisis better than any other approach currently under consideration. According to the coalition, Sorry Works! restores the provider-patient relationship and improves the communication and trust between all parties, thus reducing the filing of non-meritorious claims and saving on legal expenses (7). While the coalition believes that legislative action or mandates are not necessary preconditions for implementation of a full disclosure program, others prefer the security provided by legislation that reduces liability.

Apologies

Many people believe that disclosure is incomplete without an apology. An apology is an acknowledgment of responsibility together with an expression of remorse. There is an important distinction to be made between apologies and expressions of consolation. When a patient
experiences an unfortunate outcome that is not the result of provider error, it is appropriate to offer consoling comments, such as “I am sorry for what happened.” An apology, on the other hand, is necessary when the health care provider has harmed the patient physically or psychologically through behavior that could or should have been avoided.

At least two factors appear to hinder acknowledgment and apology for medical errors—fear of litigation and the culture of medicine. Lawyers and risk managers have routinely advised health care providers not to admit responsibility or apologize, but evidence suggests that liability costs can be reduced by full disclosure and apology. Programs of disclosure and apology at the Lexington (Kentucky) Veterans Hospital, the University of Michigan Health System, John Hopkins, and Children’s Hospitals and Clinics in Minneapolis, among others, have resulted in dramatic reductions in legal expenses.

At the Lexington VA facility, during a seven-year period, the hospital’s average payout was $16,000 per settlement, versus the national VA average of $98,000 per settlement, and only two lawsuits went to trial during a ten-year period. Expenses and lawsuits were similarly affected in Minnesota, where Children’s Hospitals and Clinics of Minnesota reduced the number of lawsuits by half. This is striking because of the hospital’s high liability exposure (many young patients) and the fact that Minnesota is a state that does not have a cap on claims.

Experts say that breakdowns in the provider-patient relationship—not communicating honestly or completely, for example—were at the root of nearly 75 percent of malpractice claims filed against physicians. One study showed that of those pursuing medical negligance claims, 91 percent reported that a desire for an explanation was the reason for the legal action.

When providers explain to patients what went wrong, accept responsibility if they are at fault, and apologize, the likelihood of a malpractice claim being filed drops dramatically.

Many articles have been written about the current “culture of medicine” that bestows an aura of infallibility on physicians and other health care providers and makes it extremely difficult for an open discussion of mistakes to occur. This culture only compounds the already emotional reaction that occurs when one makes a mistake, such as feelings of guilt and embarrassment, sorrow over causing pain to others, and fear of humiliation.

Because patients are not the only ones who are hurt when mistakes occur, changes must be made in education. Students should be taught that it is appropriate to acknowledge mistakes and essential to apologize to patients. Changes must be made in practice that help health care providers deal openly with the anguish and sense of culpability that accompany medical errors. Health care professionals should have an opportunity to move toward self-forgiveness and healing by talking with peers, trusted friends, spouses, and counselors rather than to suffer from continued guilt and depression. Morbidity and mortality conferences should not be the only venue where bad outcomes are examined and acknowledged. Patient safety experts recommend that institutions provide better support and programs for caregivers involved in such incidents, but the culture must change in all settings, not just hospitals. The current societal and professional climate needs to evolve to a better acceptance of mistakes as an inherent part of medicine, in order to encourage truth-telling.

Conclusion

Stemming the causes of medical errors requires disclosure and analysis—a transparency and openness of communication that are currently missing in health care today. Rather than foster an adversarial relationship between patients and providers, we should strive for changes that will decrease medical errors, litigation, and escalating insurance premiums. We should seek
changes that will increase the availability of providers willing to perform high risk, life-saving procedures, a culture that acknowledges human fallibility, and a system that rewards honesty.

IN THE SPIRIT OF PATIENT-CENTERED CARE, the American Academy of Physician Assistants believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. The AAPA also supports NOT ONLY THE CURRENT SCIENCE AROUND DISCLOSURE AND APOLOGY DURING CARE DELIVERY, BUT ALSO ENCOURAGES PHYSICIAN ASSISTANTS TO BE ACTIVE PARTICIPANTS IN LOCAL DISCLOSURE PROGRAMS. changes in law that encourage PAs and other health care providers to apologize without incurring increased personal liability.

References
Acknowledging and Apologizing for Adverse Outcomes
(Adopted 2007 and reaffirmed 2012)

Executive Summary of Policy Contained in this Paper

Summaries will lack rationale and background information, and may lose nuance of policy. You are highly encouraged to read the entire paper.

Improving healthcare quality and reducing preventable adverse events in care delivery continue to be a top priority for the United States health care system. Since the Institute of Medicine (IOM) published its 1999 report titled “To Err is Human: Building a Safer Health System,” emphasis and effort in reducing preventable injury and improving care delivery have taken place. Further, the discipline of disclosure of medical error has seen significant advancement.

- AAPA believes physician assistants can be more educated and involved in advancing the science of disclosing medical errors in health care.
- AAPA believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes.
- The AAPA also supports not only the current science around disclosure and apology during care delivery, but also encourages physician assistants to be active participants in local disclosure programs.
- AAPA commits to providing education to PAS and advancing the science of medical error disclosure.

The Institute of Medicine, in its 1999 report, To Err is Human: Building a Safer Health System, declared that preventable adverse events are a leading cause of death in the United States. The report estimated that more than one million preventable adverse events occur each year in this country and 44,000 to 98,000 people die in hospitals annually as a result of medical errors. Americans responded to this report by initiating efforts to reduce medical errors. The patient safety movement has focused on redesigning systems, implementing safe practices to prevent accidental injury, and establishing medical error reporting systems. Because the complete elimination of errors in medical treatment, although highly desirable, is an unattainable goal, attention is also being paid to the way institutions and caregivers respond when injuries occur.

Disclosing Errors

The IOM has previously reported that as many as 98,000 people die each year as a result of medical error (1). Adverse outcomes can occur in any health care setting, including inpatient, outpatient,
HOME AND LONG-TERM CARE (2). FURTHER, PREVENTABLE HARM FROM CARE DELIVERY IMPACTS NOT ONLY PATIENTS, BUT FAMILIES, CAREGIVERS, STAFF AND COMMUNITIES (2).

HEALTH CARE ORGANIZATIONS THAT ESTABLISH A CULTURE OF QUALITY AND SAFETY ARE MORE LIKELY TO PROACTIVELY IDENTIFY A CRISIS MANAGEMENT PLAN. THESE PLANS INCLUDE PROCESSES THAT ENHANCE COMMUNICATION BETWEEN AND AMONG ALL STAKEHOLDERS (2). THUS, EVERY HEALTH CARE ORGANIZATION SHOULD ESTABLISH A PLAN TO ADDRESS ADVERSE EVENTS. THE RESPONSE SHOULD BE PRIORITIZED TO INCLUDE 1) THE PATIENT AND FAMILY; 2) THE FRONTLINE STAFF, AND; 3) THE ORGANIZATIONAL RESPONSE (I.E. INITIATE ROOT CAUSE ANALYSIS AND CRISIS MANAGEMENT TEAM) (2).

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Disclosure is commonly defined as a prompt, truthful, and compassionate explanation of how the injury occurred, its short-and long-term effects, remedies available to the patient, and steps developed following an analysis of the root cause of the error— that will be taken to prevent its recurrence. Errors do not always constitute improper, negligent or unethical behavior, but failure to disclose them may.

THE PATIENT AND FAMILY

THE PATIENT AND FAMILY MUST BE THE PRIORITY OF THE HEALTH CARE ORGANIZATION AND THE PROVIDER BEFORE, DURING AND AFTER AN ADVERSE EVENT (2). Disclosing medical errors respects patient autonomy and truth-telling, is desired by patients, and has been endorsed by many ethicists and professional organizations (3). According to the “Guidelines for Ethical Conduct for the Physician Assistant Profession,” PAs “should disclose errors to patients if such information is significant to the patient’s interests and well being. AS DISCLOSURE SCIENCE IN HEALTH CARE CONTINUES TO DEVELOP, MUCH OF THE DATA GENERATED HIGHLIGHTS THE FUNDAMENTAL IMPORTANCE OF OPENLY ADMITTING ERROR (4). A NUMBER OF STUDIES SUGGEST THAT BOTH THE PUBLIC AND HEALTH CARE PROFESSIONALS GENERALLY AGREE THAT MEDICAL ERRORS CAUSING HARM SHOULD BE DISCLOSED TO THE PATIENT, AN APOLOGY RENDERED, AND FAIR COMPENSATION BE NEGOTIATED. THIS PROCESS HAS DEMONSTRATED A REDUCTION IN LITIGATION COSTS AND HAS BEEN WIDELY ADOPTED BY HEALTH SYSTEMS BOTH ACADEMIC AND FEDERAL (5).

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IN THE SPIRIT OF PATIENT-CENTERED CARE, the American Academy of Physician Assistants believes that patients deserve complete and honest explanations of adverse outcomes and apologies for medical mistakes. The AAPA also supports NOT ONLY THE CURRENT SCIENCE AROUND DISCLOSURE AND APOLOGY DURING CARE DELIVERY, BUT ALSO ENCOURAGES PHYSICIAN ASSISTANTS TO BE ACTIVE PARTICIPANTS IN LOCAL DISCLOSURE PROGRAMS. changes in law that encourage PAs and other health care providers to apologize without incurring increased personal liability.

References


Mister Speaker, I move that Resolution 2013-B-10 be so amended.

The Committee next considered testimony on 2013-B-11, the resolved portion of which reads:

Amend policy HX-4100.1.10 as follows:

AAPA is committed to a policy that respects the ethnic and cultural diversity of all people. The Academy's commitment to diversity is a belief in the value and worth of each VALUES ALL individuals, and a recognition that when WHEN differences BETWEEN PEOPLE in cultures and ethnic groups are understood and respected everyone in society benefits. Accepting diversity is not an attempt to eliminate or dilute the rich heritage that exists in all peoples. Accepting diversity does require an

EMBRACING DIVERSITY CELEBRATES THE RICH HERITAGE OF AMERICAN
AND GLOBAL COMMUNITIES AND PROMOTES understanding and respect for the differences that exist among all PEOPLE. physician assistants and the patients they serve.

Testimony by multiple delegates was provided; it included suggested amendments to the policy statement.

The committee considered testimony which recommended the following amendment by substitution:

Amend policy HX-4100.1.10 as follows:

AAPA respects the ethnicity and cultural diversity of all people. The Academy’s commitment to diversity values all individuals. When differences between people are respected everyone benefits. Embracing diversity celebrates the rich heritage of American and global communities and promotes understanding and respect for the differences among all people.

Mister Speaker, I move that Resolution 2013-B-11 be so amended by substitution.

The Committee next considered testimony on 2013-B-12, the resolved portion of which reads:

Be it resolved that Physician Assistants shall be recognized as “collaborative” medical professionals and that language utilizing the phrase “supervised medical provider” is a less accurate representation of the professional relationship between physicians and PAs

Pro Testimony:

Pro testimony suggested that words have power. It was expressed that we do not use the word “supervision” in its literal meaning.

The underlying sentiment for pro testimony was that there is a need to remain competitive within the healthcare system.

Con Testimony:

Con testimony surrounded recurring themes about the complexity of the definitions of the words “supervision” and “collaboration.” Concerns were voiced noting the term “collaboration” suggests there is a desire for independent practice.

Additionally, there was a sense this should not be done unilaterally by the House without input from other national physician assistant organizations and would be premature.

Furthermore, it was felt the nature of the late resolution did not allow adequate time for discussion and deliberation amongst other constituent organizations and their leaders. Nor did it allow time for the Academy’s liaisons to consult with their respective physician organizations.

However, there was agreement this issue requires further study and discussion.
Mister Speaker, I move that Resolution 2013-B-12 be referred to the appropriate body for its consideration and that its recommendation on this resolution be submitted by the 2014 House of Delegates.

Mr. Speaker, this concludes the report of Reference Committee B. I would like to thank the House Officers Alan Hull, Gail Curtis and David Jackson for their support and guidance. I would further extend gratitude and thanks to the hard work of the AAPA staff Kodi Blue Erb. I would like to thank the committee members for their hard work and being well prepared for this committee.

Respectfully submitted,

Theresa Gavula, Chair

Tim La Voy

Samantha Rogers

John Trimbath

Mark Zender

James Williamson

Jessica Wohl, Student Member