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INTERAGENCY AUTISM COORDINATING COMMITTEE

SUBCOMMITTEE FOR
BASIC AND TRANSLATIONAL RESEARCH

STRATEGIC PLAN QUESTION 1 PLANNING GROUP

CONFERENCE CALL

THURSDAY, SEPTEMBER 27, 2012

The Strategic Plan Question 1 Planning Group convened via conference call, John Robison, *Chair*, presiding.

PARTICIPANTS:

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PROCEEDINGS:

Dr. Roger Little: Good afternoon. I'd like to welcome you to the conference call for the Planning Group To Update Question 1, "When should I be concerned?" of the IACC Strategic Plan for ASD Research.

My name's Roger Little. I am acting as the designated Federal official for the call today on behalf of Dr. Susan Daniels, who's currently out on maternity leave.

On today's call, please remember to identify yourself before you speak so that we know who the speaker is and thank you all for joining us. At this time, I'd like to turn the call over to the Planning Group leader, John Robison.

Dr. John Robison: Well, thanks for joining us. I think that all of you folks got my email raising some questions about Question 1. And Alice I think had some commentary about the scope of our charge and what we're doing with revising Question 1.

But I guess I have a very fundamental issue with it, and that is that Question 1 as written in the Plan only speaks to when should I be concerned about small children, and indeed it should rightly be when should I be concerned about people of any age.

Alice, did you have some thoughts on that?

Dr. Alice Kau: Well, I’m only stating the charge that was given to us by Dr. Insel and Dr. Dawson at the bigger Basic and Biomedical Subcommittee call. So I just want to make sure that what we are doing is in line with what every other group is doing.

But I think your effort and your thinking are very right. And I wonder if we can just incorporate that into the addendum for the 2012 revision.

You know, as I remember in a bigger Subcommittee call, Dr. Insel mentioned that in 2013 we’re going to revise the entire Strategic Plan. And I wonder if maybe that will be the time to really review the whole thing.

Dr. Coleen Boyle: Alice, this is Coleen. Maybe you can just start since our collaborators Ami and -- I’m sorry, I’m forgetting Dan -- don’t know the charge so maybe we could just restate that. Alice?

Dr. Kau: Yes. And Coleen, correct me if I'm not accurate. So basically, if you have the 2011 Strategic Plan in front of you and you turn to page 10 --

Mr. Robison: That's what I emailed to everyone.

Dr. Kau: Right, right. And the paragraph started with the 2011 addendum to Question 1, "When should I be concerned." And I thought that we are supposed to follow this format. First, to update what is new in this area -- What is the new science discoveries? And the next paragraph will focus on the gaps that emerged in 2011.

And then we have a due date to turn this in as a committee -- I think the middle of October. I think October 23rd, am I right, Coleen?

Dr. Boyle: Yes.

Dr. Kau: So we do have a due date for that. That's the charge that was given to us.

And I just remember, since we have such a short time to turn this around, we don't really have time to rewrite the whole chapter. But very soon in 2013 the whole IACC Committee will be devoted to revise the entire Plan.

Mr. Robison: So then why don’t we -- in writing the 2012 addendum -- why don’t we say in the 2012 addendum right at the beginning that the Question 1 committee has recognized that the scope of this question needs to be extended beyond small children. We can add a few paragraphs there to state what we’ve articulated here. And then we can build in our “When shall I be concerned with respect to older children and adults?” into the 2012 addendum. So we’ll just really address all that in the addendum, I guess.

Dr. Kau: Right, right.

Dr. Little: Now, I’ve just received a -- I received a very nice set of comments from Ami. They just came by email just now. I don’t know if he shared them with any of the rest of you. But Ami, did you have any objection to my sending them around to everyone else on our group here?

Dr. Ami Klin: Oh, sure. This is more of a reference for the kind of discussion that we’ll have today, but please do. Please do. There are 10 points there that I’ve just mentioned on the basis of some of the comments that you had made in the original and some of the thoughts that I had about the emphasis placed on particular areas in the text. So by all means, please share this with everybody.

Can I just ask a question? So the charge of the group is to create the text that will be around about four columns, just like the 2011 addendum?

Dr. Boyle: That’s correct.

Dr. Klin: Okay.

Dr. Boyle: So basically, it will be a fairly short two-page update from the last time this was updated, which was early ‘11. And we’re really supposed to -- and having done this -- I did the update with several collaborators of this question last time around.

And we’re really trying to focus on really the seminal work in the area because obviously there’s a lot that’s been done -- but really issues that have helped move the field along and the thinking along.

So what we did last time -- and I just took a look at what was available -- was that we actually looked at what was in the summary of advances, which is also on the OARC Web-site for this question. And there really are only two articles that are featured for this question. So obviously, we definitely want to incorporate those two.

And that was an article, and you may all have this in front of you but this is one on -- the title of it was “Disrupted Neural Synchronization in Toddlers with Autism.” And that came out of Eric Courchesne’s group and published in -- I guess it was *Neuron*.

And the second one was “Detecting, Studying and Treating Autism Early: The One-Year Well-Baby Check-Up Approach.” And that was published in *The Journal of Pediatrics* and Dr. Carter -- actually Dr. Pierce is the first author on that one. So those were the only two that were highlighted in the summary advances relative to this specific Question.

And then the other issue was, since the update last time occurred fairly early in ’11, there may be other articles in ‘11 as well as in this year, in ’12, that we might want to consider. Again, and trying to think about really high-level advances and the issues that would be captured under the rubric of when should I be concerned. Hopefully that helps a bit.

Mr. Robison: What do you feel the *DSM-5* changes would have to do with the question of when should I be concerned as applied to an older person?

Dr. Boyle: I’ll probably let some of the clinicians handle that one. Ami?

Dr. Klin: Well, I don’t see major changes happening on that. I know that there has been a great deal of controversy. And Cathy, who’s not on this call, was right in the middle of it, given that she was fielding some of those questions via *The New York Times* op-ed section.

But my best understanding of the data that are available out there is the main concern that people have -- that people had -- that individuals would not meet criteria for the conditions. I believe that’s certainly not at the level that people were concerned for. Apparently we don’t need to be too concerned about that. But I think that --

Mr. Robison: Isn’t that itself newsworthy though, Ami, in terms of reporting where we stand with respect to this?

Dr. Klin: But, the –

Mr. Robison: Isn’t saying that those changes do not appear to make a big difference?

Dr. Klin: The only question I believe has to do with in which section of this document this would go. Because if we’re talking about -- primarily about -- very young children even though we can talk about individuals for whom concerns arise at any age, the issue that has been raised is whether or not those individuals who carry the diagnosis of autism spectrum -- well actually, of a mental disorder of any kind that would be new definitions and not meet criteria, and therefore they might lose eligibility for services. That’s where the controversy was.

I’m not sure that this is the place here, but I’m happy to discuss that. But still, the best person to comment on that would be Cathy, given that she was very much involved in this controversy and some of the work that she led through the Simons Foundation in the data that bear on that particular question.

Dr. Boyle: But John, maybe one way -- this is Coleen -- maybe one way of handling that is asking, since Cathy is not on the phone today with us, I know you identified her as clearly the person to provide the update in terms of the science driving the development of the *DSM-5*.

Maybe we can ask her to also either address or highlight maybe the gaps in knowledge relative to adults.

Dr. Klin: Yes, I think that the question could be phrased along these lines. *DSM-5* is going to be published in 2013, and I know that there have been a series of clinical trials, actually trials that address that question very specifically. I’m not sure what is the age range of the various different cohorts in those studies and I also don’t know whether those studies have been completed. But if there is one person who would know about that, it would be Cathy.

Dr. Boyle: Right. So we could definitely ask her in our request to her to actually try to highlight that specific issue.

Mr. Robison: Okay.

Dr. Boyle: Okay, does that sound reasonable?

Mr. Robison: Yes.

Dr. Kau: That sounds good. I agree; I think this issue needs to be patched with the *DSM-5* influences, but the details need to be filled in by Cathy and other experts.

Dr. Klin: Well, you also have at NIH, you have Sue Swedo, who actually heads the *DSM-5* task force. And so Sue would also be able to provide some additional comments, given the fact that she is heading the task force and she has been the target of a lot of those folks who are concerned about the changes in definition of what the targeted the task force. And Sue was the one heading it.

Dr. Boyle: Yes. -- in terms of what we have to do, identifying gaps, if there are already activities -- research activities that are ongoing that have not been completed -- and this way, maybe both Cathy and Sue could weigh in. We’d have to note that in here.

Dr. Kau: And you know, whatever we propose in our write-up will be vetted through the entire IACC and also the workshop on the 29th and 30th of October.

Mr. Robison: Yes.

Dr. Kau: There will be opportunity for further refinement.

Dr. Klin: So again, this is Ami, Coleen. Can I ask you -- so one of the action items, is for us to propose those articles that may have been substantial enough to be included in this update.

Dr. Boyle: Yes. That’s my thought.

Mr. Robison: Could I suggest that you email those to me? This is John Robison here. And I’ll include them in consolidating this write-up in the next two weeks and send it on to you all.

Dr. Boyle: Yes, that’s great. And John, what I was going to do is maybe even send you a little synopsis of it. For example, in the first section when it talks about what have we learned in the past, it opens up with the updated information from CDC’s Autism and Developmental Disabilities Monitoring Network.

So I can ask, as part of the new addendum I can provide you some verbiage as well as what I know about other prevalence studies that help to describe both the prevalence and maybe issues related to subpopulations, ethnic minorities, and others that may have some challenges relative to identification.

Mr. Robison: If everyone could send those things to me for, say, the middle of next week, that would be really great, because that would give me a little over a week to write this all up in some form and then send it out to all of you so that we have a chance to revise it once between us before we present it at the larger Committee on the 29th and 30th.

Dr. Kau: I suggest that we circulate all the material to the entire group --

Mr. Robison: Right.

Dr. Kau: -- so we all know what was being proposed.

Mr. Robison: Yes.

Dr. Kau: Okay, great. Thank you.

Dr. Klin: And so just to contextualize the notes that I sent to John, I was not sure whether the text itself would be revised, and now I have learned that it’s basically an addendum.

Dr. Boyle: I knew – [Inaudible comment]

Dr. Klin: So some of the comments that I placed there might be more appropriate for a future version of the IACC report than the current one. It sounds like right now our major issue is to update it in terms of any new knowledge that has occurred since 2011.

Dr. Boyle: Yes -- new knowledge and how that new knowledge has translated perhaps into identifying additional gaps -- ongoing work that has started in the interim that may fill some of the prior gaps. So that’s the whole piece.

Dr. Kau: And also if you are aware of any research opportunities, feel free to identify them. And Ami, can you circulate that email to the entire group?

Dr. Klin: Sure. So John, maybe that’s the best thing for me to do. After this call, I will go back to this note and I’ll send it to everybody.

Mr. Robison: Okay, very good. Yes, that’s good.

[Pause]

Dr. Klin: Can I just test the waters with you a little bit with one of the comments, so that I’ll know what is the context for any contributions that we try to make?

Dr. Boyle: Yes. Certainly.

Dr. Klin: Well, one of the things that -- one of the articles that you mentioned -- the Karen Pierce article, was an attempt to basically bring screening of autism to primary care physicians’ offices. So she used a screener that was developed by Amy Wetherby and was able to achieve some interesting results. And that’s the paper that Coleen mentioned was published in *The Journal of Pediatrics*.

But one of the, kind of conceptual questions that proceeded with that is this notion that in the current text we talked about the fact that parents are typically the first ones to recognize that there are any issues with the child, which is true historically.

But it would seem to me that a forward-looking document would think about, given the fact that this is a highly prevalent condition, given the fact that it seems like early diagnosis and early prevention matter a great deal, and given the fact that there are major disparities in the community in terms of access to services with minorities and low-income families -- and maybe rural populations as well -- having children diagnosed at a later stage. If we equate early diagnosis with greater potential for changing the life course of these children, then it sounds like we're coming to a point in which we can begin talking about universal screening for autism and universal screening being conducted through community-based services like primary care physicians' offices, the medical homes.

So I was just wondering if those kinds of conceptual issues really are part of this, or is this some future development.

Dr. Boyle: Well, I'll just -- this is Coleen -- I'll just react to that, Ami. Thank you for that. I would put it in -- again, this is essentially 1 study --

Dr. Klin: Um-hmmm.

Dr. Boyle: -- with 137 pediatricians in one county. So in some ways I think that sort of setting the future and where we want to go and what we think needs to happen beyond the Karen Pierce -- may be important to do. But sort of framing it as that's the direction we want to move in. And the gaps would be how we get there.

Dr. Kau: Ami, do you think we're ready for that, the measurement issues? Thirty-percent false-positive rate.

Dr. Klin: No, well, not on the basis of that study. But you probably know, Alice. --

Dr. Kau: Yes.

Dr. Klin: -- because you've been in touch. Some of those studies are ongoing on a much larger scale, and probably they're going to yield much better results. So the reason why I mentioned this is because I think that conceptually we are there on the basis of some of the things that I've just mentioned. But it might be prudent, then I'm just saying -- I’m just kind of contradicting myself -- but I’m just trying to get a sense of, given the fact that this is the first time that I’m part of this task force, do we wait for the evidence to be there in order to include the special suggestions? Or if we cross some thresholds, that it’s more conceptual then we place that as one of our wish list.

Dr. Kau: Right. So do you mean mandatory? I mean AAP has already recommended.

Dr. Klin: Well, I think that one of the issues of the AAP is that they also recommended surveillance of children beginning at the age of nine months, and this is often not talked about.

Dr. Kau: Right, right.

Dr. Klin: So, I am -- I think that I feel fine for us to wait for more solid data and for research that yields better numbers and the ones that can report it to include that. I just wanted to know we need to be concerned about the text conceptually, or we focus primarily on those -- on solid innovations that can provide us with guidance in the future.

Dr. Boyle: Well, I guess I would take a little bit different approach. Ami, this is Coleen.

Dr. Klin: Please, Coleen, teach me, because you’ve been here and I haven’t.

Dr. Boyle: No, no. I mean, I think this is sort of an “eye of the beholder” in some ways. I think this study is definitely an important aspect to point out in the first section.

And I think within the context of that first section -- in terms of what’s new and what we’ve learned -- we can in the gap part of it say what we feel needs to be in place. Some of it, as you said, is already underway. But we want to be able to drive the research in that direction.

So that’s the opportunity to say here is an advance. We know there are a number of other studies that will add -- if positive -- add a lot more credibility here.

Dr. Klin: Um-hmmm.

Dr. Boyle: -- And these are the metrics in terms of thinking about the performance of a screening test in the context of universal screening that should be in place.

And either these new studies are going to be addressing that, or that needs to be addressed. But that’s the direction we want to head in.

Dr. Klin: Um-hmmm.

Dr. Boyle: So I guess that’s how I would frame it.

Dr. Klin: Okay.

Dr. Kau: Yes, or -- Ami, I would love to have that happen. I thought maybe we can think about like what are the gaps. What else do we need to have that accomplished?

Dr. Klin: Let me -- Alice, I think you’re right. I think that one of the things that in the future I certainly -- as you know, I moved to a different city in which we embrace community challenges. So I’m totally sold to the idea that science needs to become increasingly more relevant.

Dr. Kau: Um-hmmm.

Dr. Klin: But community viable tools are something that we definitely need. So I agree with you; we’re not quite there, but that’s really so desirable.

Dr. Kau: Right.

Dr. Klin: And so that's the reason why I mentioned that we might have crossed a threshold conceptually, but we are not quite there with the data.

Dr. Kau: Yes. I would definitely, I would support putting that in as like -- somehow I have a feeling that one of our objectives has already addressed that, but I can't seem to find that here. Research opportunities. Because it is -- the ideas that have been discussed.

Dr. Boyle: So Alice, there was a King study last time around --

Dr. Kau: Right.

Dr. Boyle: -- that actually -- it was done within the context of trying to bring -- understand -- the challenges and barriers to screening and referral. So I mean, obviously the concept is there.

Dr. Kau: Yes.

Dr. Boyle: -- And then we also talk about gaps, that there's the lack of reliable and valid screening. Obviously, this is filling that gap.

But it’s already in there.

Dr. Kau: Right. So it’s a strategy including that. What age, what month, what measure do we use, and what do we do after that?

Dr. Boyle: Yes.

Dr. Kau: Referral for services and eventual diagnosis, you know the whole sequence of events that needs to follow after screening. Yes, this is so important.

[Pause]

Dr. Boyle: So Dan, your thoughts on this? Anything?

Dr. Daniel Coury: Well, yes. This has been a wonderful discussion. I think we’re talking about here two different levels of needs. One is at the level of developing an instrument like Karen Pierce has described from her study and better screening instruments that have better specificity and sensitivity.

But the other part of that, what you saw from the King study, is how can we get this reliably implemented with a high degree of consistency. And so there are two different steps in meeting this need of identifying children early and screening them.

And when Ami talks about universal screening in an ideal situation, he mentioned that parents are usually the first ones to suspect something is wrong, obviously because they have the most exposure to their child.

But if you think about other medical conditions that we have evolved to the point of providing immunizations to prevent or that we are screening for before families have any idea what to suspect -- all of our newborn screening batteries -- that is certainly a goal for all of this. We're not going to achieve it in the next five years, but it is an eventual goal.

So when Ami asks, "Is this reaching too far?" it certainly would be an endpoint. But for now, I think what we can reach for is improvements in using the tools that we have at the same time that we work on improving those tools. So I think those are two goals at this point.

Dr. Klin: Right. Just that -- this is Ami again. One thing: I'm not sure that it's part of our charge here, but the one concern that I certainly have been educated for the past close to two years is this notion that we often talk about the screening instruments as parent-based or observational. They are very -- well, they are basically open to all of the difficulties that you have with those kinds of screenings. And so autism is different from so many other medical entities for which we actually have a test, something that is either performance-based or is biologically-based.

One thing that -- and I know because I'm part of the foundation for NIH biomarkers task force -- that people are really, really, really searching for science-based ways of quantifying the condition and possibly using those things for the purpose of screening.

The one thing that I don't see amongst my colleagues and probably myself even two years ago is this notion that some effort in your design, some effort in your thinking, some effort in your grant writing also needs to embrace the challenges in the community so that we start talking about true translational science. So when people are coming up with new science that they worry about how this thing would be applied in the community.

So this is kind of a wishful thing that comes to mind when nowadays I come to meetings and we start talking about what might work out there in order to screen children. Some of those biomarkers are simply -- even if they were perfect -- they're just too expensive to be used for population-based studies. So this is the kind of consideration that certainly bothers me in some of the discussion.

Dr. Coury: I agree.

Dr. Kau: Good point.

Mr. Robison: So we have -- still, we have a large emphasis on children. Do we have any thoughts on what we might be saying about when we should be concerned on adults?

Dr. Klin: From what standpoint, John?

Mr. Robison: Well, when we look at studies like last year's study over in England showing false-normals -- 1 percent incidence of undiagnosed autism among those adult residents of the community -- it seems to me that we have a similar concern that there is a large undiagnosed population in this country, many of whom probably are what you might say underperforming or underachieving in life, and a large part of that may be a lack of awareness. So when should I be concerned might be particularly relevant to somebody who knows someone like that.

Dr. Boyle: John, this is Coleen. I think that’s a great issue, and I think we have to obviously include that looking forward. And we have to include that U.K. study and then better understand its implications.

I think -- I know we’re limited in terms of scope and size, but as Alice said, we will be revising this in 2013 and there may be an opportunity to better flesh that out. But raising that as an issue and maybe raising the implications of gaps in knowledge there is very, very important.

Mr. Robison: So maybe it’s enough to just raise the issue even though we don’t --

Dr. Boyle: Yes, yes -- the important implications that you have just talked about.

Mr. Robison: Yes.

Dr. Boyle: Yes.

Dr. Kau: I think that's a gap. Because we don't know how to approach that, and that is a knowledge gap.

Mr. Robison: Yes.

Dr. Klin: I would say, John, another thing. I think that the word "prevalence" probably might be better used because the -- I think it was Richard Grinker who said we don't have an epidemic of autism: We're finally getting things right. And the issues of ascertainment are critical.

That study, that prevalence study of adult is critical, but some people who believe that autism spectrum disorders have been around for a long, long time, the fact is that we should expect the same. It's an empirical question, but it sounds like from that study that we should expect the same rates of individuals impacted as children or as adults.

Dr. Boyle: Yes.

Dr. Klin: And so I think that what you're saying is really very, very, very important. There is a conception that there’s a very small number of adults out there, when in fact it’s very likely that the number of adults reflects the number of children that we’re finally ascertaining through this better prevalence study.

Mr. Robison: Yes, I think it’s important that we make that clear, yes.

Dr. Klin: Um-hmmm.

Dr. Boyle: There were some challenges in the study, and I think we can point those out. I would definitely think it’s an important issue for us to have further discussion with the update in 2013.

Dr. Klin: But I wonder if, John, it seems like you’re very knowledgeable of this area. I know of only that study. Are there other studies out there that focus on prevalence studies of adults?

Because this is really critical.

Mr. Robison: Well, we had that study in Korea that reported, what, 1 in 30? But that was older children, wasn’t it?

Dr. Boyle: Yes, those were adolescents.

Mr. Robison: Yes; that was teenagers. I’m not aware of another large adult study right now.

Dr. Klin: Which basically means that we would love to see more. I would hope -- I have Coleen on the call -- but I would hope that maybe the CDC might be able to sort of to address that here in Atlanta. I would love that.

Mr. Robison: So maybe that's something that should be an action item that we'd like to see funded.

Dr. Klin: But I probably should not speak about this because I'll let the epidemiologists deal with that.

Dr. Boyle: No, it's definitely been an important issue that I know our agency is interested in addressing as well as many others. I mean many other people interested in addressing that issue.

Dr. Klin: I think my concern, John --

Mr. Robison: Yes?

Dr. Klin: If I may, my concern is this the issue -- about 30 years ago, having a child with autism was a private thing that every family has to go through because of lack of awareness, lack of educational laws and everything.

I think that for many families in which there is an adult with autism, to my experience has been that it’s still a private matter, the reason being that we don’t have those kinds of institutions that basically obligate every person to be part of like schools.

And so I think that the epidemiological consideration basically a population-based study of adults, is very, very, very challenging. I’m not saying that it is not feasible; I would love to see more of that, that’s for sure. But it is challenging, more challenging I believe than what we see with school-age and even younger children.

Mr. Robison: I think that’s probably true. I think that’s probably why a lot of this was never diagnosed in the adult population.

Dr. Klin: Um-hmmm.

Mr. Robison: So I think that I’m going to try and pull together something from what everyone has -- from what everyone has said. Hopefully, we can circulate the comments. Do you think to do that, to send the preliminary document around in two weeks, is that going to give us enough time to email it back and forth and if necessary set up another call and discuss it between ourselves?

Dr. Boyle: Yes. So we have a meeting scheduled for -- is it the -- I'm going to ask --

Mr. Robison: 29th or 30th, isn't it?

Dr. Boyle: I think we're meeting on the 30th.

Mr. Robison: So we're the second day, yes.

Dr. Boyle: We're the second day. So obviously, we have to have our draft advances and gaps document together. And the content for that day would be to go through all of the questions relative to our Subcommittee's work and present what we see as the -- sort of a summary of that work. So I think that gives us sufficient time. So two weeks I think would be great.

Dr. Kau: Yes. I think our part, Question 1 draft, is due to the Basic and Translational Subcommittee on the 22nd of October.

Dr. Boyle: Okay.

Dr. Kau: So a week before the workshop.

Dr. Boyle: Okay. And so two weeks, John, would be when?

Mr. Robison: Two weeks from now would be --

let’s just see here-- it would be --

Dr. Boyle: Looks like the 11th. Is that right?

Mr. Robison: Yes, looks like the -- yes, the 11th. Yes.

Dr. Boyle: So aim for a reasonable draft by the 11th. Or at least you to get us something back. And we’ll try to get you our materials by a week from today? Would that --

Mr. Robison: I would say yes. If you -- everyone send me the materials -- we can send them amongst each other to the force.

Dr. Boyle: Okay.

Mr. Robison: Then I’ll draft -- I’ll turn it all into something for the 11th, and I’ll send it back to all of you. And then perhaps if we feel that we need to set up a telephone call, we could do that. You know, we could set a date for the week of the 15th or 20th. Otherwise, we could just conclude it by email and turn it in to the Committee.

Dr. Boyle: Okay, sounds good.

Dr. Klin: Could I just ask you, John, as we send you those recommendations regarding new work, do you want us to basically send you a PDF of the paper, or do you want us to send you a description and maybe some etiological concerns?

Mr. Robison: I would send me PDFs of papers and also send me Word documents with any comments and concerns.

Dr. Klin: Okay.

Dr. Boyle: Alright.

Dr. Klin: Sounds good.

Dr. Elizabeth Baden: Okay, everyone -- just a quick business process thing. This is Elizabeth from the Office of Autism Research Coordination.

If you could copy me and also Gemma Weiblinger on all of your email correspondence, that would be much appreciated. And I believe you all already have emails from us, so hopefully you can get our email addresses from there.

Dr. Boyle: It would be very helpful if you were to follow this call and just give us a reminder of that and then we can all reply to that email.

Dr. Baden: I can certainly do that.

Dr. Boyle: Thank you.

Mr. Robison: Well, are we good then? Are we all set?

Dr. Boyle: I think we’re good.

Dr. Kau: I have another question. So who is going to talk to Cathy about what transpired in this call?

Dr. Boyle: Well, John, were you going to write up notes at all we could share with her?

Mr. Robison: Boy.

Dr. Boyle: If not, that’s fine; that’s fine. Maybe we can send her an email summary, a very quick email summary.

Mr. Robison: Yes, if you could make her a quick email summary and send it, I’d appreciate that.

Dr. Boyle: I’ll send it to all.

Mr. Robison: Yes.

Dr. Boyle: And this way, you’re all informed of what I’ve summarized.

Mr. Robison: Alright.

Dr. Boyle: Okay?

Dr. Kau: Thank you, Coleen.

Dr. Boyle: You’re welcome.

Mr. Robison: Alright; thanks for doing that.

Dr. Boyle: No problem.

Mr. Robison: So are we all set then?

Dr. Boyle: I think we’re there.

Mr. Robison: Okay. Then I guess I’ll hear from everyone by email next week, and I’ll be back to all of you soon.

Dr. Boyle: Okay, and thank you very much for taking the leadership on this, John.

Mr. Robison: Alright. Well, thank you.

Dr. Kau: Thank you, John.

Mr. Robison: Yes, bye-bye.

Dr. Kau: Bye.

Dr. Klin: Thank you for including me. Thank you; bye-bye.

Dr. Boyle: Bye-bye, Ami.

Dr. Coury: Bye, folks.

Dr. Boyle: Bye, Dan.

(Whereupon, the Strategic Plan Question 1 Planning Group adjourned at 1:06 p.m.)