**Committee Discussion on Proposed
Action Plan of SACGHS Task Force on Education and Training**

DR. McGRATH: I would like to lead a discussion on getting a consensus on the two documents that we showed at first. Now that you understand the scope of the group, see if you think that those two documents represent accurately what we should be doing. The first one is the draft charge. Paul.

DR. BILLINGS: I have a couple of questions. I was particularly struck by the creation of a public health work force group, or subgroup, or whatever you are calling it, distinct from health professionals. Can you talk a little bit about how that came about and why that separation was made?

DR. McGRATH: Joseph is head of that group. Unfortunately, he left. But we can add the rest of the committee members with it.

It was identified that the healthcare providers were point-of-care persons, physicians, nurses, genetic counselors, that whole group of point-of-care. The public health providers were more like state officials involved in things like newborn screening policies and things like that. Does that make a reasonable distinction?

DR. BILLINGS: So, if I was a public health physician, I would be a healthcare provider and not a public health work force person?

DR. McGRATH: That is why it is one committee instead of three. That is why we will be using case studies. There is going to be overlap. You may wear one hat in one situation and another hat in another one and have different educational needs for different ones. If you were doing newborn screening, you would have to know a lot more about state policies and things like that versus if you were providing care at a community clinic. That was the thinking. Does that make sense?

DR. BILLINGS: I think if you are going to include broad constituencies outside of, let's say, traditional providers and patients, then you have hospital administrators, you have legislators who are writing legislator, you have judges doing healthcare law. You are opening it up to a larger group. I'm just curious how you are thinking about the scope of it.

DR. McGRATH: Of that one group?

DR. BILLINGS: Yes.

DR. McGRATH: That last group you just listed is one that we eliminated last time, but we did keep it in public health people.

Any other thoughts?

DR. AMOS: We have heard a lot from industry this morning, different companies. It seems to me that there may be some need to educate up and coming new companies on what are the expectations for scientific rigor that is going to be required for the general genetics community to accept their technologies. Was there ever any discussion about working with industry?

DR. McGRATH: I think in the early discussion -- and those of you who are here, jump in -- that was in a long list of groups that could easily be included. We kept coming back to point-of-care notions and limiting it to that. That was just a decision made. The line had to be drawn someplace.

DR. AMOS: I just think that you might actually remove some of the roadblocks and actually may be able to be a part of the process of getting more clinically relevant, useful diagnostic tests out there by working with industry closely.

DR. McGRATH: Sherrie first.

DR. FITZGERALD: Is this -- oh, I'm sorry. What?

DR. McGRATH: You are not Sherrie.

[Laughter.]

DR. FITZGERALD: I'm speaking for her. No, no.

DR. HANS: Just a quick comment. I'm struck with the Public Health Providers Workgroup that perhaps you don't have the range of expertise that you need on the group. You might think about trying to get some additional members on there from outside the current committee, either from CDC colleagues who are involved in the education of public health providers or groups like the American Public Health Association.

It is a particular diverse group of practitioners, and I think you need that expertise on the workgroup itself in addition to contacting those groups and getting information from them. I think there is a knowledge and understanding that isn't captured in the current workgroup.

DR. McGRATH: That is a good suggestion. We had made a decision, but we can certainly revisit that, of keeping the workgroup to that size and having a really robust communication using people like that as consultants rather than having them on the group themselves. It is something to revisit. Thank you. Yes.

DR. FITZGERALD: You have DTC down here, though, under different settings. So you will be addressing that issue?

DR. McGRATH: Yes. I was just thinking about adding a response because the idea of the case study around DTC is it is from the lens of the consumer. The case study will be of a person going through that experience. But the way we are envisioning writing it, they will come in contact with various people who also have educational needs. That will allow us to cast that web a little bit wider. That is when I was thinking maybe that is the place to bring in some of the industry perspective but not as the sole focus. Is that what you were getting at, Kevin?

DR. FITZGERALD: To some extent. It is not just direct-to-consumer testing, though.

DR. McGRATH: Right, right, right. One more. Rochelle.

MS. DREYFUSS: I have a very tiny quibble with the original statement of goals. You used the words "increased understanding of genetic testing" and then you talk about the need for

education. If we understand it more, do we need the education? You might just want to say an increase in production of genetic information rather than increasing understanding.

For somebody who has never seen this before, it is kind of confusing.

DR. McGRATH: Good. Thank you. Any other comments so we could reach consensus on those two?

DR. TEUTSCH: With those changes I assume that we have consensus on the charge. The one thing that we of course have to still pick up is the information that we get from the priorities process. Obviously, Paul is going to talk a little bit about that as we get back to that. But there are issues there that we will be looking to this committee to incorporate as well.

Cathy?

DR. FOMOUS: Rochelle, just to go back to clarify what you are wanting, this is in the paragraph that talks about the specific charge?

MS. DREYFUSS: Yes. The fourth line down. I just saw it on the slide.

DR. FOMOUS: I'm just trying to find where you want the change or what you want exactly.

MS. DREYFUSS: I don't have it in front of me. If you could just go back to the slide of the charge. It was right at the very beginning. Keep going back. "Leading to a better understanding of disease."

DR. FOMOUS: Oh, the very first sentence.

MS. DREYFUSS: Yes. It just looks like we all understand it.

DR. FOMOUS: So, what would you prefer?

MS. DREYFUSS: "Better information" or "more information." Maybe it is fine, but it looked to me like if there is better understanding why do you need more education.

DR. FOMOUS: So it is leading to more information about disease processes.

DR. FROSST: You could probably sub in the word "insight" in there.

MS. DREYFUSS: Yes, that's good.

DR. FOMOUS: I didn't hear that. Put "insight"?

DR. FROSST: Use the word "insight" instead of "understanding."

MS. DREYFUSS: Thank you.

DR. TEUTSCH: All right. Very good. Thanks so much, Barbara. We appreciate your doing that. You will have your work cut out for you.