HIT Policy Committee
DRAFT
Summary of the January 14, 2014 Meeting

ATTENDANCE

Members present:

- Madhulika Agarwal
- Christine Bechtel
- Neil Calman
- Arthur Davidson
- Paul Egerman
- Judith Faulkner
- Charles Kennedy
- David Kotz
- David Lansky
- Devin Mann
- Aury Nagy
- Marc Probst
- Joshua Sharfstein
- Robert Tagalicod
- Paul Tang
- Thomas Greig

Members absent:

- David Bates
- Patrick Conway
- Scott Gottlieb
- Gayle Harrell
- Deven McGraw
- Troy Seagondollar
- Alicia Staley

KEY TOPICS

Call to Order

Michelle Consolazio, Office of the National Coordinator (ONC), welcomed participants to the 55th meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee (FACA) meeting being conducted with two opportunities for public comment and that a transcript will be posted on the ONC website. She instructed members to identify themselves for the transcript before speaking. Members introduced themselves.

Remarks

New National Coordinator and Chairperson Karen DeSalvo thanked everyone for her warm reception. She thanked Jacob Reider for serving as acting coordinator. She described her background, beginning as the daughter of a single parent who emphasized self-care and prevention, and her receipt of health care in the public sector. She is a physician who trained at Tulane Medical School and Charity Hospital. She

worked in a state health department and in the National Health Service Corps. After Katrina, everything changed. She participated in rebuilding the New Orleans infrastructure around primary care and prevention with HIT playing a central role. She observed that ONC is more than content expertize. HIT can be a leader in delivery reform.

Review of Agenda

Vice Chairperson Paul Tang noted each of the items on the agenda, which was distributed by e-mail prior to the meeting. No additions to the agenda were requested. He asked for a motion to approve the summary of the December meeting, saying that he had submitted edits directly to Consolazio. A motion was made and seconded to approve the meeting summary as circulated with the meeting materials. The motion carried unanimously by voice vote.

> **Action item #1: The summary of the December 2014 HITPC meeting was approved as distributed.**

CMS Update

Robert Anthony, Centers for Medicare and Medicaid Services (CMS), showed slides and presented his standard monthly report. Attestation typically increases in January and February. As of November 2013, 93 percent of EHs had registered and 86 percent had received an EHR incentive payment. Nearly 60 percent of Medicare EPs are meaningful users of EHRs. Approximately 76 percent of Medicaid EPs have received an EHR incentive payment, and 17 percent of Medicaid EPs are meaningful users. Over 63 percent of Medicare and Medicaid EPs have made a financial commitment to an EHR. Over 330,000 Medicare and Medicaid EPs have received an EHR incentive payment. Regarding EH attestation for core measures, only one objective, CPOE for medication orders, fell below 95 percent. Performance on menu items is lower, particularly for the public health objectives. Over three years, performance of returning EHs held steady. EP performance is above 85 percent for core objectives except for CPOE, clinical summaries, and medication problem list. Overall, performance on menu objectives is lower compared to core objectives. Performance over the three-year period is generally comparable. Additional data are available on the CMS website.

ONC Update

Jennifer King showed slides and talked about progress as of November 2013. Eighty-three percent of EHs, representing 92 percent of Medicare discharges, have attested, as have 49 percent of EPs. Regarding their primary vendor, 86 percent of EHs that attested to Stage 1 used a primary vendor that had any 2014 Edition product as of December 31. Seventy percent of EPs that attested to Stage 1 used a primary vendor that had any 2014 Edition product. She reported on a review of 493 studies by Jones, Rudin, and Shekelle in a recent issue of the *Annals of Internal Medicine.* They found that 60 percent of the studies included in the review reported that meaningful use functionalities have predominantly positive effects on quality, safety, and efficiency outcomes; only 6 percent of the studies indicated predominately negative outcomes. The remainder cited mixed results. Health IT effects varied by type of outcome, but were mostly positive overall. The Health IT literature is expanding rapidly. Studies are needed on how context and implementation affect value. There is considerable variation in the extent to which the different functionalities have been studied. She cited two studies based on NAMCS data that found that the majority of EP EHR users perceived benefits, which appeared to increase with the experience of the user. The survey panel will be followed over three years to determine patterns of change in use.

Q&A

David Lansky asked about comparing early and later adopters on outcomes. Anthony indicated that CMS is looking at this comparison, although no analysis has been contracted. According to King, ONC is

evaluating HITECH programs, including outcomes based on Medicaid claims data. The study will extend through 2015.

Paul Egerman announced that he liked the colored bar charts. He inquired about the number of vendors certified for Stage 2 compared to certification for Stage 1. King responded that she did not have those numbers, although fewer vendors are certified for 2014. Otherwise, there are no good data on market concentration. Anthony acknowledged that concentration has taken place with acquisitions and sales. Egerman observed that many of the studies on the impact of functionalities cited by King were published prior to meaningful use; they are really studies of the effect of automation, not meaningful use. King acknowledged that data for many of the studies were collected prior to the incentive program. However, the functionalities considered were restricted to those in meaningful use.

Judy Faulkner referred to slides 13 and 19. Most vendors already had these attributes before meaningful use. So what, really, is the effect of meaningful use? What are vendors not doing now that they could have been doing without meaningful use? How many vendors entered the market before and after meaningful use? The vendors listed by King as having the largest market share for the 2014 Edition already had those products on the market before meaningful use. It was pointed out to Faulkner that the information presented by King was not intended to answer those questions. Anthony said that the number of vendors is shrinking. With the onset of incentives, new vendors came forward, but many were not successful with sales.

Marc Probst talked about the importance of anticipating how providers will be affected by Stage 2. Anthony reported that CMS is in receipt of concerns of interest group representatives over the timeline of implementation. It appears that the timeline to certification and from certification to implementation is a primary concern. A fair amount of products are available. Probst said that a factual analysis is needed. King said that NCHS will soon publish findings on adoption based on survey data from early 2013. The American Hospital Association's annual survey data on adoption of functionalities will be available in February or March. ONC staff is working with RECs on assembling data on similar topics.

Robert Tagalicod reminded the members that CMS must consider Stage 2 in conjunction with ICD-10 and other CMS initiatives. Everything must be taken into account in evaluating impact on providers. He promised that small and rural hospitals will not be left behind.

Christine Bechtel asked King to explain more about the low perceived benefit of EHRs on patient communication. King reminded Bechtel that the data reflect responses to a survey question and do not allow exploration of details. The survey was conducted in 2011.

Another member cautioned against over-interpretation of survey results. King said that the studies were based on quantitative data. Qualitative studies may shed additional light. At this time, ONC is not funding similar studies.

Public Health Update

Art Davidson gave a slide presentation on the Stage 1 public health and population health measures, efforts on standards and interoperability framework components, and readiness for Stage 3 measures. Davidson thanked ONC and the CSTE for their assistance. In year three, 80 percent of hospitals achieved at least one of the three public health measures, with immunization (64 percent) far outdistancing electronic lab reporting (20 percent) and syndromic surveillance (25 percent). Regarding immunization, an improved implementation guide (IG) (V2.5.1 – 8/1/2012) was published; public health agencies are increasingly accepting certified product data (HL7: 58 percent in 2011 to 77 percent in 2012), and the upcoming IG (February 2014) will include bi-directional exchange with history and forecast back to the provider. For electronic laboratory reporting, an improved IG version is generally available through HL7 at http://www.hl7.org/dstucomments/showdetail.cfm?dstuid=104. A successful centralized infrastructure

utilizing BioSense is available for syndronic surveillance. At least five of the ONC S&I Framework projects—CCDA, Query Health, Structured Data Capture, Health eDecisions, and Data Access Framework—can be leveraged for public health.

In Stage 3, the cancer reporting IG should move to consolidated clinical document architecture (c-CDA) because EHR vendors are required to use this format for transition of care documents in Stage 2. This eliminates the burden of supporting two different formats for cancer reporting. The CCDA has harmonized and improved templates across multiple sources, and the cancer reporting program is ready to move to this new standard. Planned next steps are to: align the cancer reporting IG sections with CCDA sections; add a new document-level template CCDA R2 (Ambulatory Healthcare Provider Cancer Event Report); add cancer diagnosis section to CCDA; analyze gaps and overlaps; and put the new document through the HL7 ballot process by May 2014. Immunization and electronic lab reporting will remain the same. The CDC HAI reporting system was described; several structured data capture projects are feeding into the system as well as into EHDI and notifiable disease reporting. Health eDecisions pilots are expected to contribute to CDS sharing. Long term, there are plans for the Reportable Condition Knowledge Management System (RCKMS), in which one repository will hold information on all conditions. Davidson described three potential methods for registry participation. One method is standard message structured data capture enhanced CCDA message. The second is a modified CCDA to limit protected health information release to community-based, high priority condition registries, and the third is federated query technologies. In conclusion, Davidson said that Stage 1 measures are advancing well; S&I Framework projects are making progress on interoperability and standards; and the prospects for Stage 3 readiness are good. However, he acknowledged that pilot projects require additional implementation testing.

Discussion

Tang asked about barriers to complete adoption. Jim Daniel, ONC, said that providers and public health agencies need to agree on the use of the standards. Implementation guides must be issued and followed.

DeSalvo referred to the capability of state and local health departments, saying that participation may be difficult in those states in which the local health departments are responsible for surveillance. She also wondered about preparedness. She went on to remind the group that population health includes persons who do not use the health care system. Therefore, other sources of information, such as social services, must be leveraged. Daniel reported that he had talked to CDC officials. ONC staff intends to develop an overall S&I Framework for public health, which will focus on business problems. Regarding preparedness, some use cases, such as influenza, are being identified. DeSalvo said that persons who are out of care and who need help must be identified. Davidson observed that the HITPC focuses on EHRs. Although he would like to link with schools and other community partners, such linkages are not really in the purview of the FACAs. But standards will help to communicate across sectors. Tagalicod referred to HRSA's involvement.

Lansky asked about the relationship between quality measurement and public health. Ideally, there should be universal access to data. Daniel pointed to projects in New York and Michigan as examples of synergy of quality measures and public health. Quality measures and public health should be aligned. Davidson observed that reporting to cancer registries via CCDAs presents an opportunity to consider a quality measure.

Neil Calman commented on the importance of reporting how the data have changed outcomes. Telling stories is important. Someone should think about how to move public health information back to patients. Davidson related that, in Denver, he is working to compile BMI data and to get reports to public health officials, community organizations, and the patient. For instance, if providers could show their patients a walking trail or a list of recreation center classes, they could be more effective than by simply

recommending more exercise. Daniel mentioned pilots for consumers to have access to immunization registries in Indiana and Louisiana.

Patient Matching Update

Kate Black, ONC, related that in 2011, the HITPC made recommendations that included standardization of data elements and other best practices. In late 2012 and 2013, a number of industry groups began work to improve patient matching, including the Care Connectivity Consortium, CHIME, HIMSS, HealtheWay, and CommonWell. In 2013, ONC contracted with Audacious Inquiry to identify issues related to patient matching. Lee Stevens, ONC, described the project. The scope of work was limited to clinical patient matching with a focus on standards needed. Issues of data quality and algorithmic matching came up in the discussions, but were not part of the scope. Many organizations were involved.

The following barriers to accurate matching were identified:

- Inconsistent formatting within data fields is widespread.
- Mistakes in data entry, such as transposition, require sophisticated software to adjust or take them into account.
- Smaller organizations and practices may not be able to afford sophisticated matching methods and algorithms, and their practice software may not offer such capability.
- Patient engagement efforts have not yet evolved to ensure that consumers can routinely access their demographic information to confirm and update it, either with the help of a staff member or independently via a portal.

Stevens presented and elaborated on initial "findings," along with rationales:

- Standardized patient identifiers should be used in the relevant exchange transactions.
- Certification criteria could be introduced that would enable certified EHR technology (CEHRT) to capture the data attributes that would be needed in the standardized patient identifier content.
- Study the ability of additional, non-traditional data attributes to improve patient matching. Data attributes include: email address, mother's first and maiden name, father's first and last name, place of birth, driver's license number, passport number, or eye color.
- Develop or support an open source algorithm that could be utilized by vendors to test the accuracy of their patient matching algorithms or be utilized by vendors that do not currently have patient matching capabilities built into their systems.
- Consider adding certification criteria to demonstrate the ability of a system to generate and provide to end users reports that detail potential duplicate patient records.
- Build on the initial best practices that emerged during the environmental scan by convening industry stakeholders to consider a more formal structure for establishing best practices for the matching process and data governance.
- Develop best practices and policies to encourage consumers to keep their information current and accurate.
- Work with health care professional associations and the Safety Assurance Factors for EHR Resilience (SAFER) Guide to develop and disseminate educational and training materials detailing best practices for accurately capturing and consistently verifying patient data attributes.

Q&A

Egerman noted the importance of having a complete list of and codes for gender categories. He wondered about the usefulness of an open source algorithm given the wide variation in practices. The Privacy and Security Tiger Team recommended against a universal algorithm. Stevens explained that he did not recommend prescription of an algorithm, only that one be available to test against. Its use would be completely voluntary. In disaster preparedness and response, the ability to match in unexpected situations

is important. Even small, remote organizations could be designated triage centers. For instance, in Los Angeles, the population would have to evacuate on foot into the dessert and present at small clinics.

Probst asked about the positive impact of a national ID. Stevens indicated that he is prohibited from speaking in favor of such. In some systems, a federally assigned identifier, SSI for example, produces a low match rate. The environmental scan revealed that everyone wants a universal identifier. Probst observed that his credit cards function well in that regard. DeSalvo wondered about the use of insurance exchange Direct addresses. Stevens indicated that the addresses may be a promising avenue. Nevertheless, he was reluctant to say so openly. Depending on the involvement of consumers, addresses may be useful attributes. Egerman talked about alternatives at the state level, such as driver's licenses.

Doug Fridsma, ONC, referred to the National Strategy for Trusted Identities and triangulating identities. He suggested that the issue be framed in terms of benefits to the patient from accurate matching.

Quality Measures Update

Quality Measures Workgroup Chairperson Helen Burstin presented recommendations in six domains, (which were listed on the slides): safety, population and public health, efficiency, patient engagement, functional status, and care coordination. Domain specific measure recommendations included data sources, examples, and infrastructure needs. In addition, the workgroup recommended the use of the following criteria in measure development:

- Preference for eCQMs or measures that leverage data from HIT systems (e.g., clinical decision support) and include "HIT sensitivity" – EHR systems that help improve quality of care (e.g., CDS, CPOE for accuracy and content of order, structured referral documentation)
- Enables patient-focused and patient-centered view of longitudinal care across EPs or EHs, groups of providers, with non-eligible providers, and with the broadest possible experience of the patient/population reflected in measurement (e.g., require interoperable systems) – longitudinal view, continuum of care
- Supports health risk status assessment and outcomes that can be used for risk adjusting other measures and assessing change in outcomes to drive improvement
- Preference for reporting once across programs that aggregate data reporting (e.g., PCMH, MSSP, HRRP, CAHPS)
- Benefits of measuring and improving population health outweighs the burden of organizational data collection and implementation
- Promotes shared responsibility in which the measure requires collaboration and/or interoperability across settings and providers
- Promotes efficiency
- Uses existing measures or build measures where the denominator can be adjusted for population health reporting and supports group reporting options (e.g., in CMS reporting programs)

The workgroup favors innovation and therefore went on to recommend that ONC and CMS should consider an optional "innovation pathway" whereby participants would be able to waive one or more objectives by demonstrating that they are collecting data for measures used for internal quality improvement or by integrating with a clinical data registry. Also, ONC and CMS should specify the gaps that an innovation pathway should help close, including identifying measure gaps for specialty providers. Two possible approaches for implementing an innovation pathway were noted. A conservative approach might allow "Certified Development Organizations" to develop, release and report proprietary CQM. An alternate approach might open the process to any EP or EH but constrain allowable eCQMs via measure design software (e.g., Measure Authoring Tool). The Vendor Tiger Team commented that an innovation pathway would be costly to create, maintain, and build into systems. Validating data would also be costly. It recommended that this approach should not be required for certification.

The workgroup also supports the recommendations on PGHD from the Consumer Empowerment Workgroup and the ongoing work of the HITSC Consumer Technology Workgroup and endorsed the extension of standards into additional domains that include the non-traditional determinants of health.

Discussion

Probst asked about the consumers of quality measures. Burstin said that research to date indicates that consumers themselves do not use the measures. They are used by payers.

Bechtel referred to slide 6 and dependencies, saying that more work is needed. The committee should assign the work. Quality Measures Workgroup Co-chair Terry Cullen agreed on the importance of the topic. Burstin asked about levers to push the topic forward. Regarding benefit and burden, Bechtel urged more attention on the burden to whom. She suggested that the concept be reframed in order to achieve a better balance. In addition, she commented on the importance of data collection fitting the work flow of providers, patients, and organizations. The concept of usefulness to consumers and purchasers is missing. According to her, consumers increasing use data to select providers. Tang said that multiple data sources are available. Data are not limited to EHRs. Bechtel went on to say that the language in slide 19 is preferable to that of slide 18 on an innovation pathway. Tang instructed Burstin to add the language from the Meaningful Use Workgroup.

Davidson inquired about recommendations from the Vendor Tiger Team about PGHD. Kevin Larsen, ONC, said that the Tiger Team did not focus on that topic. Bechtel reminded the members that the Consumer Empowerment Workgroup had made recommendations. The HITSC is working on devise standards for PGHD.

Regarding CMS and reimbursement, CMS staff wants to simplify measures across all programs, but there may be statutory limitations. More than a technical fix may be required. Staff is trying to align PQRS and meaningful use. A member referred to a new depression screening code and wondered about plans to introduce similar screenings, such as functional status.

Tang asked for a motion to approve the report and recommendations of the Quality Measures Workgroup. The motion was made, seconded, and unanimously approved.

> **Action item #2: The recommendations presented by the Quality Measures Workgroup were unanimously approved by voice vote.**

Consolazio noted the presence of Joshua Sharfstein.

Public Comment

A representative of the American Nurses Association welcomed DeSalvo. Noting that Blue Button technology and Direct will underpin much of the consumer engagement effort, he described the proliferation of Direct addresses and requested that the committee work to simplify Direct addresses, thereby making patient communication easier.

Accountable Care Workgroup and Accountable Care Hearing Update

Accountable Care Workgroup Chair Charles Kennedy reminded committee members that the workgroup is charged to make recommendations on how HHS policies and programs can advance the evolution of a health IT infrastructure that enables providers to improve care and population health while reducing costs under accountable care arrangements. A public hearing was convened December 5. Co-chair Grace Terrell described the goals and structure of the hearing. Kennedy showed slides and described nine key challenges based on testimonies of panelists. Data integration across EHR systems and with population health platforms is a major challenge for providers collaborating under accountable care arrangements. Technical, strategic, and financial considerations continue to inhibit providers from exchanging

information to support care coordination. While providers in accountable care arrangements are acutely experiencing these challenges today, they do not have the leverage to drive solutions alone. HIEs are facilitating exchange for accountable care in select markets, but sustainability and spread are still a major concern. There is lack of clarity and consensus around the key quality measures; many are still focused on simply reporting compliance. ACOs need to do more to prioritize a patient-centered approach to care. Smaller organizations are facing challenges in making IT investments and meeting the administrative burden associated with value-based payment models. Providers under accountable care arrangements face barriers to obtaining critical information around behavioral health and other sensitive conditions in order to inform care decisions.

Based upon the testimonies of invited panelists, workgroup members selected the following topics for discussion as they formulate recommendations:

- Additional mechanisms to ensure certified EHR products effectively implement exchange
- Strategies to support seamless integration between EHRs and other applications supporting population health and care coordination, e.g. analytics tools
- Opportunities to incentivize health information exchange through federal programs focused on accountable care
- Increasing provider access to comprehensive cost and utilization data
- Facilitating integration with LTPAC, behavioral health, social and community services, and other providers serving high-risk or high-cost patients
- Encouraging the availability and adoption of tools and data that support care management for high-risk and high-cost patients

Discussion

DeSalvo wondered about the availability of case studies or other information to illuminate the conclusions. Terrell replied that although the workgroup did not conduct case studies, panelists made various materials available in the public record.

Calman described his experience in working on the capability to generate alerts to on-calls via the HIE. PCPs want to know about costs and prices of specialists' services prior to making referrals. Someone should think about how to build in ways to generate this information.

Lansky advocated that the workgroup solicit information from purchasers. In his experience, purchasers are forced to be very intrusive to obtain the information they want. He recommended that the workgroup think about IT capabilities that will be important regardless of the survival of the ACO business model. What are the public policy issues for the committee? The roles of public policy and private organizations should be differentiated. Terrell reported that workgroup members were surveyed regarding this division. There was no consensus and certainly not a perceived need for a lot of regulation.

Tang reported that several Accountable Care Workgroup members participated in the Quality Measures Accountable Care Subgroup.

ONC Policy Update

Jodi Daniel talked about several new publications. SAFER Guides with patient safety risk assessment tools will be released this month. Under a guidance issued in July, ONC-ACBs are required to conduct surveillance (including live surveillance in the field) of CEHRT. Surveillance focuses on specific safety-related capabilities as well as EHR technology developers' processes for receiving and responding to user complaints. ONC-ACBs submitted their annual surveillance plans for 2014 and began conducting surveillance in accordance with those plans this month. ONC, after consulting with OCR and OGC, issued guidance clarifying that an ONC-ACB's authorized surveillance of CEHRT (including safety-

related capabilities) qualifies as a "health oversight activity" under HIPAA. The National eHealth Collaborative convened the PGHD Technical Expert Panel, which recently released three reports.

OIG and CMS released final rules revising the Anti-Kickback Statute Safe Harbor and Stark Law exception, respectively, for certain arrangements involving the donation of EHRs to allow smaller provider groups to accept gifts of EHR software without violating the law. The exception is extended until December 31, 2021. Interoperability requirements aligned with the ONC certification program were also revised.

ONC posted several work products including an identity management educational resource, a whitepaper on a trust framework, a preliminary HIE Certification and Accreditation Landscape and the final report from the National HIE Governance Forum. The National eHealth Collaborative (NeHC) convened the National HIE Governance Forum at ONC's request as part of ONC's national HIE governance strategy.

As a result of the HHS announcement in December of the extension of Stage 2, the 2015 Edition of certification criteria will allow for certification criteria to be updated more frequently. The 2015 Edition is completely voluntary. EHR technology certified to the 2014 Edition will not need to recertify. The Federal Health IT Strategic Plan is being updated and a draft will be presented at the February 4 meeting. A comment period will be in effect.

ONC Standards Update

Doug Fridsma showed slides and reported on the S&I Framework operating metrics. He reported on the current status of each of the 15 active projects in his portfolio. Concerning the current status of structured data capture, he said that The Patient Safety Event/Adverse Event Pilot SWG will launch February 3 in partnership with AHRQ and FDA. Staff is completing mapping of common formats to standard terminologies and reviewing Stage 2 alignments to PSE. Two implementation guides are targeted for development based on SOAP/SAML and REST/OAuth standards. The SOAP/SAML IG will undergo end-to-end consensus in January with a target date of February 10 for publication. Volume I of the SDC profile is targeted for completion on January 17. REST/OAuth IG will be balloted through HL7 in 2014 in alignment with publication of HL7 FHIR Resources. The Public Health Tiger Team identified three use cases for piloting: EHDI, cancer and case reporting. Regarding the data access framework (DAF), the local use case consensus was approved December 12. The targeted DAF use case launched December 11. The aim is to reach consensus by mid-February 2014. The DAF IHE/S&I Joint Technical Workgroup convened November 25; it is led by Keith Boone (IHE/PCC) and (Dragon) Nagesh Bashyam (S&I). This group meets weekly to support the advancement of the whitepaper regarding the overall DAF technical solution. The whitepaper will be reviewed at IHE Domain Volume One meeting February 2, 2014 in Vienna, Austria.

Q&A

In response to a question about the 2015 Edition, Daniel said that a NPRM will be issued. It is voluntary for Stage 2 and will be preparation for Stage 3. Fridsma said that this will help to avoid certification for things that are not quite right, allowing vendors to fix things. Egerman said that a fix mechanism is acceptable, but he is opposed to getting a running start on Stage 3 through certification to functions not actually included in Stage 3. Daniel said that gap certification is available.

Faulkner said that any change requires many hours of programming. Daniel repeated that a proposed rule will be put out for comment.

Public Comment

None

Chairperson's Closing Comment

DeSalvo thanked everyone for the informative and well-prepared reports and discussions. In particular, she thanked Consolazio for her efforts in organizing the HITPC.

SUMMARY OF ACTION ITEMS

Action item #1: The summary of the December 2013 HITPC meeting was approved as distributed.

Action item #2: The recommendations presented by the Quality Measures Workgroup were unanimously approved by voice vote.

Meeting Materials

- Agenda
- Summary of December 2013 meeting
- Presentations and reports slides