

Health Information Technology Advisory Committee

Annual Report Workgroup Virtual Meeting

Transcript | May 11, 2026, 3 – 4:30 PM ET

Attendance

Members

Eliel Oliveira, Connexus, Texas HIE, Co-Chair
Shila Blend, North Dakota Health Information Network, Co-Chair
Hans Buitendijk, Oracle Health
Michael Chiang, National Institutes of Health
Steven Eichner, Texas Department of State Health Services
Hannah Galvin, Cambridge Health Alliance
Anna McCollister, Individual
Rochelle Prosser, Orchid Healthcare Solutions
Naresh Sundar Rajan, Neantix.Inc

Members Not in Attendance

Bryant Thomas Karras, Washington State Dept. of Health
Kikelomo Oshunkentan, Humana
Mark Sendak, Vega Health

ONC Staff

Tara Porter, Designated Federal Officer
Peter Karras, HITAC Support Team
Maggie Zeng, HITAC Support Team

Call to Order/Roll Call (00:00:00)

Tara Porter

Good afternoon, everybody. Welcome to today's annual report workgroup meeting. I am Tara Porter with ONC, and I will be serving as the designated federal officer for today's meeting. I want to note that all workgroup meetings are open to the public, and public feedback is welcomed. Members of the public can make comments in the Zoom chat feature throughout the meeting, and we also have a portion towards the end of the agenda scheduled for verbal comments as well. Next slide, please. Thank you. Today's agenda will begin with a quick roll call, and the bulk of today's meeting will be a discussion of draft crosswalk of topics for the HITAC annual report for FY '26, and then we will close out with the public comment portion. Next slide, please. Thank you. I will now begin with roll call of the work members. When I call your name, if you could just please indicate that you are present, starting with our co-chairs, Eliel Oliveira.

Eliel Oliveira

Present. Good afternoon.

Tara Porter

Good afternoon. Shila Blend.

Shila Blend

Present.

Tara Porter

Hans Buitendijk.

Hans Buitendijk

Good afternoon.

Tara Porter

Michael Chiang.

Michael Chiang

Present. Thank you.

Tara Porter

Steve Eichner.

Steven Eichner

Present.

Tara Porter

Hannah Galvin has noted that she will be joining a little bit late today. Bryant Thomas Karras. Anna McCollister. Dayo Oshunkentan. She has a conflict today and was not able to join. Rochelle Prosser. Mark Sendak. Naresh Sundar Rajan.

Naresh Sundar Rajan

Good afternoon. Present.

Tara Porter

Thank you, Anna, I will circle back. I see that you just joined. Thank you. I will now turn it over to Shila to kick off the rest of today's meeting.

Opening Remarks (00:02:13)

Shila Blend

Thank you, everyone, for joining us today, and as well as thank you for joining last week as we discussed this topic as well in the in-person HITAC meeting. To start off, we are going to talk about the timeline. Next slide. As you can see on the timeline, the next two weeks, the plan is to discuss the priority target area of interoperability. In June, we will discuss privacy and security. Going to July, we will be doing the patient access to information. Then closing up in August, coming up to discuss the health IT infrastructure landscape, and then we will be reviewing that draft

annual report and presenting it at the HITAC meeting in September. Following that, we will be finalizing this along with your comments throughout the end of October. In November, the plan is to have our vote on the final annual report. Next slide. To kick off the discussion of the crosswalk topics, I am going to hand it over to Eliel.

Discussion of Draft Crosswalk of Topics for the HITAC Annual Report for FY26 (00:03:37)

Eliel Oliveira

Thank you, Shila. Accel team, if we can open the crosswalk, I think we are going to get started today on that. I do not know if all of you have been part of the annual report work group, but this is the format that we capture our thoughts and suggestions, recommendations. As you can see here, the document is organized by priority target area with interoperability being the first one. If you can scroll up a bit, the Accel team, you will see that we will eventually get to the privacy and security and to patient access to information. We can go back to the top. That is how we are going to organize our thoughts. Then, you see five columns here where we spend the bulk of our time today and for the last three months. The first tab column is to address the gap. What is the problem state that you have for this specific topic? What is the missing capability? What is not in place or missing that is causing the problem?

What is the challenge based on that gap, the difficulty in solving and the barriers and why is it not in place? What is getting in the way that is causing that gap? Then what are the opportunities, what can be done about it, the potential, what are the possibilities we could explore, pursue? Finally, I will propose recommendations, recommended HITAC activities. What specific actions should ONC HITAC propose? Then, we have that final column there that last year was quite useful because we had quite a few topic areas that we decided to define if some of them are immediate that need to be addressed as soon as possible and others are more long term. That is going to just be what we fill that column with, either immediate or long term. The bulk of work is those four first columns, as you can see. If need be, I think it might be helpful, Tara, for the next meeting share, actually maybe not focus, we can as well, the last year's report, so that folks can get an idea of proposed recommended activities.

For instance, it might be useful for you to think about it. We are proposing a hearing or some legislation, even. What aspects? How do we list those proposed activities there or recommended activities to HITAC, to ONC? Let me start then, unless anybody has any questions, please stop me. I want to start by reading the first topic and then we can jump into the gap. What we said there for interoperability was that we need to improve multimodal interoperability across key domains, data domains, clinical, laboratory, pharmacy, imaging, claims, public health research for key user domains, patients, providers, payers, researchers, public health agencies and pharmaceuticals. What is the gap, the problem that we have? What is missing or not in place that is causing this issue? Steve, go ahead.

Steven Eichner

Just to back up for a second, can we define what is meant by multimodal? As a second comment, thinking about key data domains, I have some challenges in thinking about those data domains as being silos. I really do not think of them as being silos. I think it is all health data and there may be different entities interested in the data, but it is not an overlapping or separate set of categories. Public health may be very interested in the very same data that a health care practitioner is, laboratory, etc. I am not sure we really can chunk it as different data domains.

Eliel Oliveira

Any comments back to Steve there on multimodal? I have my thoughts, but I wanted to see if others have any feedback there. Shila, I see your hand.

Shila Blend

Mine was for a comment. I can add my thoughts on Steve's comment, too, but I was going to wait and see if anybody else had anything. I will put my hand down. I see Hans or Michael.

Hans Buitendijk

Yes, my comment is that I had the same question as Steve, what is meant with multimodal? I do not have a particular proposal for that, but regarding the second comment, perhaps I was looking at data domains and user domains a little bit more in two dimensional and, therefore, users can touch any of the data domains and vice versa. I think that should allow us to make any comments or suggestions on gaps, challenges, etc., whether they are specific to a particular combination, pharmacy in the context of researchers, for example, or a comment that cuts across everything where it is approached. If we can provide more context, be more specific, great. These will be the triggers to really think about where the gaps are. I did not see it as a limitation per se.

Eliel Oliveira

Michael, your thoughts?

Michael Chiang

Yes, Eliel. I do not think I was sophisticated enough to think about questions of definitions as much as thoughts about possible ways to fill in the boxes. When I think about interoperability, to my view, one of the challenges is that I think everybody believes in interoperability. To me, the barrier is that everybody wants everybody else to use their system not for them to use someone else's, not to convert to some other way of doing things. I guess the way that I look at that is sticks and carrots. Clearly, ONC has the ability to put sticks out there. I feel like that would be my proposed recommendation for HITAC activities to identify areas where there are challenges in interoperability within a given domain and to identify what levers does ONC have to push the field forward? I feel like one of those sticks is just rulemaking. I think one possible carrot may be challenge competitions to put out a challenge the community, wanted, some way to demonstrate, in this case, multimodal interoperability. There is going to be a prize package to do it.

That is something that we have used at National Institutes of Health (NIH) before. If you feel like that is an avenue for potential collaboration, I would love to explore that.

Eliel Oliveira

Yes, Thank you, Michael. Rochelle, I see your hand up. Go ahead.

Rochelle Prosser

Hi. I guess my question when I was listening to Steve and Ike, the question is, are we using this generalized view of data so that anyone could be able to define its meaningful use so that we do not get us or get ourselves into a box? When we are looking at interoperability, we are also looking at meaningful use. I just wanted to have that clarified. We are not putting guardrails on it so it can be more broad, so we can then provide feedback should there be questions about it. Is that my understanding of what Steve just said or Ike just said?

Eliel Oliveira

Ike, do you want to clarify that?

Steven Eichner

Is that to me?

Eliel Oliveira

Yes, I think that was to you.

Steven Eichner

Just thinking about it a little deeper, if we shift the idea of data domain or maybe data domain here means data system from a pure technology standpoint, thinking about a clinical data system or a laboratory system or pharmacy system that today may not be fully interoperable with other systems. Pharmacy does not necessarily talk all that well with some other systems. That interoperability, I think, makes a lot more sense from an enhancement standpoint to help address the sharing of information where it is appropriate so that the users, whatever system they are using, if you will, have access to the information they need to get their job done. Maybe that is what we mean by a data domain if it is tied to particular technology with, again, what historically has been a particular set or focus of interoperability that may have only been in that specific service area.

Rochelle Prosser

I am in agreement with that. Thank you.

Eliel Oliveira

Yes, so after hearing what everybody is saying, I am thinking here that if I am reading this sentence as it is, and I do not want to center the discussion on these initial topics because I think we could talk more about the gap. Then, that gap can lead us in fixing how we are wording the topic. What I am reading, improved multimodal interoperability, that is already putting the focus on multimodal, which I understand what it is, is text, video, audio, imaging, all kinds of things. Is that really the problem that we are trying to address? I do not think that is. I think that focus on multimodal, if we wanted to keep it, could go elsewhere. More important than that, if I am hearing what Steve is saying and what I feel as well is when I look at those domains, clinical, laboratory, pharmacy,

imaging claims, public health and research, again, it could be systems as well, like Steve was saying, the world that I live in as an HIE is that it is a broken system where integrating data is very painful in terms of laboratory and pharmacy, for instance, in imaging with organizations.

There is a lot of control and price discussions and agreements. When, in my opinion, if a piece of information is needed to treat a patient for care coordination or for payment, healthcare operations, it should be available to the users that we are describing there. If a provider needs to know the lab results, the pharmacy and the image that have been done about an individual, it should not be limited because of an organization that manages that imaging company or the pharmacy has their walls on integrating data. That is, to me, the big problem here that I would understand, it is like one of these users that need access to some of those data, but we do not get that because there are several gaps or walls that prevent that from happening. I will stop there. Those are my thoughts. Shila, I see you next.

Shila Blend

Yes, I was just going to make a comment. My feeling on it, if multimodal is the hang-up, if we really look at what they mean, interoperability, we are already seeing the ability to utilize different system software to communicate and exchange data across this. If you look at multimodal, I am wondering if we are just duplicating because in essence, that you are looking at different types of systems, communications, using multiple modes to convey that information and do things. I think the question we have to ask ourselves in that is, are we saying the same thing, saying multimodal and interoperability? I know the slight nuances saying well, we have different modes of communication, but so do you in interoperability. That is a little piece I want to add in there as we talk about this and discuss it moving forward.

Elieil Oliveira

Thank you, Shila. Hannah, I see your hand up.

Anna McCollister

Yes. I was in transit and on my mobile. I could not figure out how to unmute myself and you are taking roll call, so sorry about that, Tara. My thought about this, and I guess it is part of what bothers me about a lot of our discussions, and it is not about just HITAC, but about all of these discussions at large, is that so much about this is focused on data and the clinic as if the only use of data that is generated in the clinical setting is in the clinical setting. This data is generated by patients. We use it outside of the clinical setting. It needs to be available and interoperable with tools that are outside of the clinical setting. Much of it is about patient data access. I feel that is gen one of this issue. Gen two, and I think this is a large part of what the health tech ecosystem thing that Amy Gleason is really trying to get at, is this data should be liquid to and from patients.

To the extent to which I think I understand what we are saying with multimodal, I feel that it is that, too, that it is interacting with my mobile phone and interoperable with my PC or the home computer because the point of this data is to improve health and to use it to treat and manage disease. Very little that actually happens in a clinical setting, particularly when it comes to chronic disease. By thinking of it within the confines of a clinical setting, we are limiting the utility of the data as well as the agency of the patients.

Elieil Oliveira

Thank you, Anna. Hans, I see your hand up.

Hans Buitendijk

Yes. Based on some of the discussion is that I am wondering whether the term multimodal can be interpreted in a very positive way on the variety of different ways in which it needs to occur. Also, it is a bit challenging. One of the mindsets that would come up in my mind is that, are we going to have different standards for the same data that really should benefit from using the same standards? That is not the kind of multimodal that I think we are necessarily looking for. To me, it is more confusing then, that it is adding interoperability is already indicating that. If you look at the difference for key user domains, many of the aspects to what is the best way to share clinical data between patients and providers, what is the best way to share pharmacy data between public health agencies and pharmaceuticals, etc., these combinations are already telling a lot about the variety of different aspects we look at. Depending on context, it might be more important than the other. In the end, we are trying to share the data across all stakeholders as needed, whether it is clinical, pharmaceutical claims, administrative, etc.

I actually feel fairly comfortable with multimodal not being part of the definition here. Maybe do it as key data/data/system domains to make it across systems, across the kinds of data that we need to have. It is really a

many to many relationship among these dimensions to share that. What are key gaps? One that just jumps out is that in a number, this is not the only one, not necessarily the most important one, but as I am trying to work that through imaging, is that a big gap is the ability to share an imaging link in a fashion that when a patient or a provider or somebody else that needs it, that they can actually access from a different system for the back system. Otherwise, that is one of the key challenges. Another challenge is the funding of that. That is not a capability, but without the appropriate funding, that we might have the capability, but it is not going to happen, not necessarily because people do not want to share it, but the infrastructure to build it is not there. Just picking on one example, I think there are opportunities with the statement to tease out a number of gaps that we want to highlight.

Eliel Oliveira

Yes, Thank you Hans. Before I pass it on to you, Steve, I guess one thing that I wanted to maybe bring everybody to think about is the column gap, where it says how do we state the problem that we feel that we are trying to address here because I feel like we can better frame the topic itself in a different way, and yes, remove multimodal, make some adjustments, but what is the problem that we are trying to address, truly? Just think about that for a second. Steve, I will pass it on to you and then we will go back to that.

Steven Eichner

That was a perfect segue. Thank you so much for saying that, Eliel, because that was about where I was going to go with the comments because I think part of the issue is looking at, and maybe a multimodal thing, but moving on to the gap analysis piece, I think it is really looking at access to the information, wherever it is with the add-on that it should be accessible in multiple ways and with a special eye to patients, not having to go to multiple systems to get all my information, so that I do not have to as a patient to my healthcare provider, my pharmacy, my payer, and four other sites to get my comprehensive information. It would be great if I had one place to go to get it all. Looking at the analogy from Lord of the Rings, one ring to rule them all, as it were.

Eliel Oliveira

I like that, Steve, and that may help us invert a bit how we are describing the topic here, which is how do we make interoperability work for specific users? I think maybe that was Anna's thoughts as well, related to the work that Amy Gleason is doing, which is a lot focused on the patient, but also on the providers. We have addressed payers and researchers and public health on that front, but I guess the point is how do we make these users get that data easily, like you described, Steve, as opposed to going through so many different systems? Michael, I will turn it to you first.

Michael Chiang

Eliel, I just have a couple comments about the gap that you prompted us. I think, to me, one of the challenges is that different user groups have different requirements in terms of the data. To a doctor, to a regular clinician or to a patient, I will just use images as an example, although I think this probably applies to any data type, the doctor or the patient may just want to see the picture to be able to make a diagnosis. Somebody from public health or research or other doctors might want to get raw data from that image to do something with raw data, get some numbers out of it. To me, that is one of the gaps, that it is very easy to satisfy the requirement without really satisfying the requirement if you are not sending raw data back and forth. That would be No. 1. Another gap that I see is that one thing that I have learned from being on ONC, from being on HITAC, is that the scope of ONC does not always extend to everything that I thought it extended to.

How do we have influence on areas that really are not within the scope of ONC? I think, to Anna's point, one of the things I learned is that patient access is one area to maybe work in, even when something is not within the charge of the ONC. I just wanted to make those points about different uses for different people, potentially defaulting to raw data access through standards, and also a scoping issue.

Eliel Oliveira

Thank you, Michael. Hans?

Hans Buitendijk

I am somewhat intrigued by Steve's comments to maybe the Lord of the Rings having one super ring out there. That starts to make me think are we going to have one Electronic Health Record (EHR) for the United States, or one system that can do everything? I am not convinced about that, which really means is that we are dealing with multiple systems for different purposes that have shared interest in data as the patient moves around from one provider to another, etc. That means is that we need to solve the problem of sharing that data. That is interoperability. We need to make that as easy as possible for whomever the user is. For a patient, that means is

that I should not have to log into 15 different portals to make it happen. One query that goes to everybody gets it into my place is the more likely direction. Whatever else to make that easier, but does that necessarily mean it needs to first sit in one system? Well, if it needs to sit in one system, it needs to get there. I think in the end, it is still about there are systems that are out there that have a common interest in data, where they are not the original generator of it, but it is generated elsewhere.

We need to figure that out. What can we do better so that it is as frictionless as possible, as seamless as possible, transparent as possible, and can scale so that it is easy for any user to get access to that data that they need at that point in time? What is the best way to do it short of having one super system that I am not sure whether the United States is even big enough for that?

Elie Oliveira

Thank you, Hans. Anna, I see your hand up again.

Anna McCollister

Yes. One just quick clarification of scope that was prompted by what Michael said, is he was talking about ONC. My understanding, which may be completely wrong, is that this is a report to Congress about things that need to be considered outside of the existing law. It may be part of the existing law, but does it necessarily need to be limited to the existing law on the books for what is currently ONC's remit? In other words, we can think more broadly about what needs to happen within the context of health IT, as opposed to just what is currently prescribed to ONC. Is that correct, Tara or whoever?

Peter Karras

Yes. I will jump in just to make a comment. Just to highlight and piggybacking off of what Anna is saying, per Cures, HITAC recommend standards, implementation specifications, and certification criteria to advance electronic access, exchange, and use of Electronic Health Information (EHI). Now, with that caveat, this report is the work of HITAC. Implementation of recommendations is, obviously, subject to ONC's authorities around, let us say, coordinating around nationwide health IT policy, so convening, listening sessions, stakeholder engagement, engagement with other federal partners, our authority around the certification of health IT through our ONC health IT certification program, information blocking, standards development, and then even adoption of those standards through our certification program, whether that be content standards like we have seen in the United States Core Data for Interoperability (USCDI), technological standards, and supporting nationwide data exchange frameworks, which our vehicle for that is through the Trusted Exchange Framework and Common Agreement. I think someone mentioned funding or exploring innovation projects. Those authorities and availability of resources, those are constraints or framing around implementation of recommendations.

Going back to the point, this is HITAC's report, so that would not necessarily preclude the group from, let us say, a recommendation that might be around exploring additional funding that maybe the group wants to petition Congress for around supporting a specific function or maybe specific policy or technological or economic type of factors around recommendations. Just flagging implementation of recommendations is subject to our authorities. To Anna's point, it is not precluding you all from potentially exploring things that might be outside of those authorities and availability of resources.

Elie Oliveira

Thank you, Peter. Any follow-up questions?

Anna McCollister

Should we be very specific and say that Cures should be amended to do X, Y, Z, if that is a thing that we decide? I know you cannot advise on legislation. Is that the kind of thing that we could do?

Peter Karras

I think what is the most beneficial would be what could be the most impactful, given the understanding the caveat of what is within our authorities, but there is no preclusion per se. I think just looking through the particular topics and understanding the gaps and the challenges, there is definitely room for HITAC to explore specific things. I will just say things are subject to our authorities. It is just something to keep in mind. It is not our place to be prescriptive with you all. This is the work of HITAC. I just wanted to flag the things that I noted.

Anna McCollister

I do not think we want to go super rogue, but if there is an issue that was not anticipated by Cures or whatever, I feel like we should have the latitude to be able to say, "This is a thing that needs to be addressed."

Peter Karras

Yes. I think it is good to balance that with also things that are actionable. In proposed recommendations, there are things that we could pursue, and there are things that are for consideration, as this would get transmitted to Congress and various readers of the report. It is a balance.

Anna McCollister

Thank you.

Eliel Oliveira

Thank you, Peter.

Hans Buitendijk

I put in the chat that if I hear that correctly, then the example that I started with imaging can be a column. We are not able to share them to the extent that we would like to, that the gap that needs to be worked on improving the links that can be shared so that they are accessible and across firewalls, etc. There is funding. Those are the challenges, and then whatever opportunities ONC, Centers for Medicare & Medicaid Services (CMS), others might have to address that.

Anna McCollister

One of the other gaps with particularly ophthalmology images, and I think you all know that that is an issue that is near and dear to my heart and life, is that there is a claim by the imaging device manufacturers of ownership of the raw data of the images as part of the intellectual property. Therefore, I had a researcher, a doctor at Hopkins who wanted to do some research around improving algorithms for interpreting images with artificial intelligence (AI), and they could not get access to the raw data that was generated at Hopkins to be able to do an analysis. You could see the data, but they could not actually improve upon the analytical tools because the manufacturer claimed that that raw data, not the algorithms, but the raw data is intellectual property, which to me is not an appropriate stance for them to have.

Eliel Oliveira

Yes. I want to see if we can get a bit more specific here. I do not remember who first offered this topic and why multimodal got in there, if it was because of imaging sharing was the key issue or not, but I wanted to see if we can at least agree here what is the true problem that we are trying to address because I am still not clear. I think Hans gave a good example on how if we identify in Column A that image sharing is an issue, we can devise the other aspects. I just do not know if that is the case. One thought that I had on this is that I think interoperability is still a challenge. We all know that. We now know that Amy Gleason is working at CMS trying to get patients, providers, and payers to more seamless access data and share. I think one issue that I see is even if she is successful that laboratory data, pharmacy data, imaging, along with other pieces are going to still be blocked. It is still very difficult to get a hold of data and make data complete.

Data is very fragmented nationally and data completeness is not easy to achieve because each one of those other types of organizations create walls, if you will. Again, that is my view of the problem that we have all these user types, but they cannot get to the data really because it is not granular or liquid like we talked in the meeting in-person, but also because folks are just still blocking. Again, is that the problem that we are trying to address? I wanted to focus on again, what do we put in that problem statement in the gap? Sorry, folks, if I am going backwards here, but any thoughts? Go ahead, Anna.

Anna McCollister

Yes. I am sorry to put it in chat, but I will just say it because it is faster. One of the big issues with imaging that I discovered is that a lot of it, particularly specialty imaging, is not incorporated into the EHR. Again, it lives in these devices and these bespoke systems and it is not interoperable. It is not accessible by patients and there may have been a time where that was less relevant, but as AI becomes more and more sophisticated with home computers, being able to analyze your images over time is something that more and more people are doing. It is better to have a real image as opposed to just a Portable Document Format (PDF) of the image. I think that is important, but the way that these data are stored, and Michael knows more about this than me in terms of the specifics, but my understanding based off of my querying of my doctors, is that these data are stored in these specific devices. It cannot even like be taken from the device and exchanged with the raw data.

Secondly, I think one of the big issues that we are attempting to solve with the health tech ecosystem, and I know there is a lot of work being done around Individual Access Services (IAS) specifically that I have not been involved with but Sequoia has been leading on behalf of ONC, is patient access to data that is not linked to the portal. We are, basically, just driving people to their portals the way things are currently structured. I do not think that that is an appropriate requirement for patients being able to access their data. There are too many things that can and do go wrong if you require portal mediated access. The data frequently is just not there, and it is not reliable from a patient perspective. We are still at a point, unfortunately, where the most effective way of getting good, clean data from one doctor to another is often through the patient. Making that something that is a given, as opposed to something that has to be driven through the portal, I think, is just as essential as getting it from one doctor to the next.

Eliel Oliveira

Right. That is helpful because I think what you were describing brings back multimodal as being an important piece of this discussion. I was not sure because, again, it was added afterwards, but it seems to me like imaging is an issue for many. If I understood correctly, what you are saying is the sharing maybe through different organizations might be harder because I kept thinking in my head, "If I was a patient and I had my images, what am I going to do with this stuff?" Yes, if I have the rights to it, then I can share with someone that may need to provide me with some value. That might be getting where we need this to be fleshed out better. I will stop talking and Rochelle, let me hear what you have to say, and then Michael.

Rochelle Prosser

Yes, hi. I am just sharing for more clarity for you, Eliel. I think I had brought this topic here from last year, and the experience was having to share brain images from the child's perspective, going from a regional hospital to a tertiary hospital where they needed trauma services or something along those lines. Currently, the data sharing between those facilities, unless it was an actual sister hospital entity, that sharing could not occur. It caused the child to undergo additional radiation or re-imaging, that is a re-radiation risk because even though you would give them another means of sharing this information, it was not the point and click. You literally had to download it on a Digital Versatile Disc (DVD) or a Compact Disc Read-Only Memory (CD-ROM), and then hope that the receiving hospital had software imaging or re-imaging capabilities that were compatible with the information that was loaded on the disc. A lot of times, it is not. You end up having to increase dollars. You are spending more healthcare dollars just to have the same service if you had originally just went to that initial facility in the first place. A lot of the people in the country cannot go to that first facility.

They have to go somewhere else first. Understanding that, these images cannot be shared often. It is the nurse chasing an ambulance down the highway because they forgot to take it with them. Or in the case of my daughter, trying to share information from a research hospital to either a regional hospital or another facility that is not research capable. Patients should have the right to be able to access their information as they need it, and they should also have the right to share it with whom they wish to share it with. Right now, that is not possible. This is why I put a different approach to say multimodal meeting, whether it is photographs, whether it is images, sometimes you just need to print it off on the darn X-ray film so that you can see what you need to see in order to share it appropriately.

Eliel Oliveira

I put the definition of it in the chat. Yes, it can be images, it can be text, it can be audio, it can be video, sensory data from some devices as well. I will stop there. Michael, let me see what you have.

Michael Chiang

I think that these were super important and very frustrating anecdotes that were shared by Rochelle and Anna. Rochelle and Anna, if I understand in your cases, these were cases where the patient is getting access to the raw data as a go-between because the doctors cannot send it doctor to doctor, so it has to go through the patient.

Rochelle Prosser

Exactly, exactly.

Michael Chiang

That is such a frustrating workaround I feel like, but we see it all the time. Eliel, I have a suggestion for a gap in the problem statement that I think follows on this. It would be the inability to access images and other data in raw data form, in an open standard, for example, Digital Imaging and Communications in Medicine (DICOM) for imaging,

and also with adequate metadata because to me, that is the problem that I am seeing that I feel like addresses with that you can see the picture as well as see the raw data and all the numbers that are associated with it. I think the other challenge is that data can still in 2026 be locked in proprietary formats.

Elie Oliveira

Right, right. Thank you, Mike. That is very helpful as well. Accel team, I cannot edit the document, but I think it might be helpful to make some adjustments. I am thinking improve multimodal and in parentheses a definition of it, which could be such as text, image, audio, video, and sensory data. That way, we know that that is what we mean by that. I am not sure interoperability across key data domains, but it seems like interoperability across different key users maybe, like we are describing here. I like the problem statement that Michael had as well, that we may be able to type it in there, or Michael, if you can type on the chat, maybe we can use that. I feel like we need to start making some edits here to incorporate on that. I do not know if you want to do on the call or make those revisions later. Hans?

Hans Buitendijk

Two questions or two comments. On that note, will we have between meetings a shared document of sorts, spreadsheets, otherwise that we can start to contribute offline, some of these thoughts that we now have good idea what things we are looking for that we can contribute? That would be great in preparation for the next sessions. The other part is that, following a little bit up on Michael Chiang's, the access to raw data, perhaps the gap statement, and that is the lines for imaging, but others will have other ones as well, is that it is the challenge to get access either to view it or to get the data. Both are challenged the moment that you start to be outside of the health organization where the images were taken to get that remote, quote, unquote, access that passed along access. I think we need to keep in mind is that one of the ways that that can be achieved is by passing the actual image along from the original system that captured it, Programmable Automation Controller (PAC) system, the Magnetic Resonance Imaging (MRI) machine and PAC system, and then on to IRS, on to EHR, on to the patient, and constantly move that actual image along, or the other one goes back to links, so that I can go to the source that is most suited to maintain those, rather than having them everywhere.

If we look at the size of example that was recently used, [inaudible] [00:48:42] data worth of images, we are not going to share that around on patient apps. We are not going to share it around on the EHRs for those very large images. How can we get to it? When you need to get the full image, great, but we need to have that maybe in this context also multimodal opportunity to get the viewer, to get the image, and to do so without encumbering other systems in between to have to store it just for the purpose of passing it along.

Elie Oliveira

Thank you. Peter, go for it.

Peter Karras

Yes, and I just wanted to note for folks, the language that is in the topic column is not necessarily set in stone. There is opportunity to wordsmith throughout the entirety of the annual report workgroup. I think what is important is to look at the content and see if the topic is meeting the spirit of what we are trying to address, and really just in an effort to make sure that we get to a point where we can go through gaps, challenges, opportunities, and proposed recommendations. To Elie's point earlier, as the workgroup members move through that process, I think some of the wordsmithing might come to light a little bit later downstream in terms of how do we exactly want to denote this particular topic, or how do we want to update the specific language. I just wanted to put that as food for thought of just looking at a topic as meeting the spirit of the thing that is trying to be addressed with the understanding that wordsmithing can happen throughout and not necessarily feeling the need to get the exact language and words correct right now in this moment within the various topic lists.

Elie Oliveira

Yes, Thank you, Peter. Yes, I think that is what I was trying to refer to as well, is that the topic itself, we can make adjustments. I think I like Han's suggestion of having maybe an Excel spreadsheet somewhere in Google Drive that we can all type in some of those suggested languages, that then we can have a discussion and basically define what exactly. I think this discussion has been helpful. Early in the discussion, I was thinking that this has nothing to do with multimodal, and it is not going that direction. Then now, to realize that actually we are really talking about that in imaging and multimodal pieces of data as well. In my head, it is a full circle. I think we are saying the problem statement here is sharing imaging and multimodal files is a problem because I think what we are saying here, the difficulty is the fact that it is standards and availability of viewers or access of those raw formats are difficult.

I think what I heard a lot is the big barrier is the fact that organizations may not have the capabilities to actually share that type of data. That is what we are saying that the opportunity might be that the patient itself is who can take ownership of that to allow that sharing to take place more efficiently. From there, if that is what we are seeing from there, we can think about some proposed recommendations on HITAC activities to address that. I will stop there. I think that is the picture that I got in my head now. I think that might be what I heard from everybody. Steven, I hear you. I see your hand up. Any thoughts there?

Steven Eichner

Friendly amendment. I think it also should be either transparent or require minimal action on the actors to make the image available. In other words a patient may not have a bunch of extra knowledge or know what a PACS system is and should not have to know the details of what PACS system a particular facility is using. They should be able to focus on I want the image and here is the format that I can use it in and not be overly burdened with what it takes to get it from Point A to point B. I do think there is a responsibility for somebody to identify what kind of format they can receive.

Eliel Oliveira

Right. Your note on the chat also helps clarify that, Steve. Thank you. Seeing Rochelle's comment as well, saying that I was correct on my visualization of the problem, challenge, and opportunity here. I wanted to pause that for a second if anyone has any additional comments on that because if we do not, I think the recording and the Accel team captured that thought process of what we are really describing here. We can wordsmith that and put that content and send that around to everyone later for review. We can jump to the next line, unless anyone has major concerns on what I was trying to state very briefly here in terms of what the problem is, why it is so difficult, and what can be done about it. If that is the understanding, what would be some proposed recommended HITAC activities, actions that HITAC ONC should propose?

Rochelle Prosser

Before the change in administration, I believe the Food and Drug Administration (FDA) and the NIH were beginning to look at image sharing and image sharing interoperability and capabilities. I was starting to listen to a few of those meetings where they were bringing in the experts. I am wondering do we bring in some people to talk about PACS or talk about certain requirements? The way that I see it is improved communication between devices and individuals and looking at where we are currently and what other groups are doing this or working on this well so that we can hear what the groundswell is and then incorporate good, bad, ugly of what they are doing.

Eliel Oliveira

I like that, Rochelle, I think that is right in line of where there is a public hearing or a panel discussion, but I think this can get very technical, and we do not want it to be technical. We want to make sure that is easier for individuals and users to actually access, but I can see as well that there are many types. Imaging is one aspect, but we talked about devices, implementable defibrillators, insulin pump, all that stuff that Anna was detailing here. I think there is a set of experts that we can bring in to highlight a bit of the challenges. From there, maybe lead to a discussion of what we can do about that challenge. A panel or hearing session would be great, but Anna, what are the thoughts you have had?

Anna McCollister

From an imaging perspective, I feel like CMS probably has the most power, and I do not completely understand the specific levers that would be best to use. Do not reimburse for tests done on devices that do not allow raw data to be accessed. Obviously, there would be a lot of expensive devices that have been purchased by different academic research centers. That would create problems and that would need to be considered, but maybe have some sort of a time limit or find a way to tax the device manufacturers as opposed to the academic research facilities or ophthalmologists who have the devices. It should not be a thing that is happening in 2026. We fought this battle for too long in too many different domains. Why is this still a thing? It needs to be addressed head on, not letting this be a thing. It is not intellectual property. It is the data generated about through an individual's ophthalmology or cardiac device.

Eliel Oliveira

Yes. Thank you, and I think that is a great point where Michael was talking about the carrot and stick earlier, and I think the stick is something that we are not relying as much, but instead the carrots. I think CMS would have those carrots to basically say, "Yes, we will provide resources to implement this specific type of data capture or imaging

capture,” but it then needs to be made available by incentives, and many of these other sensory data that comes out of devices in hospital systems that could also be made available through the patient. Michael?

Michael Chiang

Yes, Eiel, I really appreciate that line of thinking here that Anna’s talking about. I think that the doctors will view this as I am predicting, enormous stick rather than a carrot because what we are saying is that you are not going to get paid, unless you use this device, whereas right now they are getting paid for doing studies that really cannot get used, in some cases, by anybody else except them. If we went that route, I actually would be supportive of that. I guess it would require collaborations with CMS or potentially with FDA depending on the nature of the machine that is creating the data. For FDA, it might be, “Well, we are not approving this, unless it can speak to other machines or EHRs,” or whatever. For CMS, it would be, “We will not pay for this.” The argument would be that in the US in 2026, we should not have silos of information or it would be like having electricity plugs that are not the same for everybody, and that we have to move beyond that. I guess that is a long way of saying, 1.) I think that is a very aggressive approach, 2.) maybe it is what we need in 2026.

Eiel Oliveira

Michael, if you think about the fact that when we look at the best data that we have in EHRs, is anything that Current Procedural Terminology (CPT), International Classification of Diseases (ICD)-9, anything that is related to payment, it is very well filled in, does not miss, but whenever you are talking about things that there is not a direct payment path, we just do not get the data very clean. People do not take the time to put in the right thing. Maybe with imaging, that could be the solution as well. The incentives are there, then it becomes available.

Anna McCollister

Again, it is not just imaging data. My good friend, Hugo Campos, has an implanted defibrillator. He has to get the device off of eBay that physicians use to be able to read the data, to be able to see his own defibrillator data. It is super important for him to be able to know how the defibrillator is working and to be able to anticipate batteries dying or other types of issues. You can get shocks, apparently, from these devices, if they are not operating correctly. You can see some of the malfunctions and the data before it actually happens. I do not know this issue that well. This is just from stuff that I have heard from patients that have experienced it and tried to get access to their data and were blocked because the manufacturer does not allow them to be able to access it. The doctors have to access it through some sort of proprietary viewing system that is not part of the broader EHR.

Eiel Oliveira

Thank you, Anna. I feel like we need to maybe move on to the next line. I want to make sure that everybody at least at a high level understands what we just described here. We proposed a few things already in terms of a listening session and maybe some incentives or carrots and sticks there that we need to consider. We have enough clarity here on this line so that the team can make some edits. Next time we meet, we can revisit and make adjustments. Does everybody feel that way? Hearing none, I think we are good. The next line we have is improve the availability and use of patient generated health data. Again, it will be great if the person that suggested this topic could start. Anna?

Anna McCollister

Yes. As I think you all know, this has been a big issue of mine for quite some time. I have continuous glucose monitoring data that I generate 24/7, insulin pump data that I generate 24/7. None of that gets incorporated into the EHR. In some cases, that does not matter. Particularly within the context of introducing AI into the clinical setting, it greatly matters. It certainly matters in terms of understanding blood pressure data. It still blows my mind that we cannot have patient generated, home use blood pressure data uploaded to the EHR. It is so ridiculously difficult to share. Part of that is the blood pressure monitoring companies have made it more difficult over time, weirdly, to be able to access the data. They have the proprietary systems. Part of it is the fact that the EHRs just do not give patients the ability to write data to the EHR. This has been an issue for a very long time in terms of having the full context for the patient’s health.

As again, we move towards automated whatever we are calling it, decision support interventions or tools or AI based off of data from the clinical record used in the clinical setting, it is more and more important. Things like I have an advanced chronic kidney disease (CKD). My digital scale says a lot. I weigh myself every morning. It says a lot of stuff that my nephrologist would probably find informative like when we talk as opposed to me just estimating it when we have a conversation. That is incredibly important for people who are experiencing cardiac failure. It is just time. One of the other things that is coming to mind is things like very simple patient reported outcomes, validated things such as PHQ-9 and the GAD-8 structured super easy. That stuff is not interoperable.

That is not shareable from one facility to the next. I am sure that there are plenty of others that are structured and should be pretty easy to share from one place to the next, and they are not.

Eliel Oliveira

Would you agree, in a device part of your discussion, not the PRO, but that if a device is FDA approved, meaning we trust the data that that device is generating, we should have a pathway for providers to be able to get that data, whether it really goes into EHR or a link becomes available automatically that the provider can access, or there are warning points that are sent to a provider to note that you are off range? I think my point is, if it is FDA approved, it should become available to providers.

Anna McCollister

This is an argument that I have made for about 10 years, if not longer. I went back and forth about this several times with Jeff Shuren when he was in charge of the Center for Devices and Radiological Health (CDRH). He claimed the FDA did not have statutory authority to require that. I countered that FDA now, and this was five years ago, seven years ago, longer, has the ability to do much more robust detection of errors and issues with medical devices by having access to data streams. Since the advent of more and more sophisticated AI, that is very much within the reach of the agency, as opposed to some of the more analog ways of capturing medical device failure data that they have been using for years. I have not worked on any FDA advisory committees related to this. It has been several years, so I do not really know what the latest is on what they are doing. That was Jeff Shuren's retort to me when I said that I did not think the FDA was living up to their statutory authority for true device surveillance and keeping patients safe.

He said he did not feel like they had the statutory authority to do that. That was a point of disagreement that did not really go anywhere.

Eliel Oliveira

I think in respect of that, we can still make our recommendations up to the Secretary or others to make a decision. We are running out of time pretty quick, I cannot believe it, but we have about five minutes until public comment, and then we can come back if there are no public comments. Steve, I want to hear what you have to say before we get to that point.

Steven Eichner

Sure, really quickly, I think it is probably about the incorporation of patient-generated data rather than the availability, just as a wordsmithing piece because it is really a matter of incorporating that data into usage, not just the data being available.

Eliel Oliveira

I agree.

Steven Eichner

That is really the goal at the end of the day. I think looking at licensing or validating equipment, it might be that there is value in branding, if you will, from the FDA perspective, as something being interoperable, as a value of a second level of service. There should also be the ability to have an FDA product that was not certified for interoperability because if a patient wants to maintain their privacy and not share their data, they should also probably have the right to not engage in data sharing. Now, there may be medical implications down the line, but that might be a patient choice rather than forced sharing put upon them.

Eliel Oliveira

Yes. Thank you, Steve. That makes sense. Rochelle, three minutes.

Rochelle Prosser

Quickly, for me, looking at patient reporting outcomes, we currently have a system where physicians can put in for metrics and reimbursement under value-based care based on the patient reporting outcomes that they are currently looking at today. It is a very slim and narrow line. My thought is there is a lot of other data that patients are filling in and reporting for patient reported outcomes, but it is on a PDF. You are using an iPad and filling out a form. When it is shared between other entities, it is sent as a PDF. Again, the raw data concerns all of those things. Being able to access and catalog and look at the trends within the data, that is not a plausible thing. Also, in wearing these downloadable devices, I am not sure who had mentioned that they had to go out and buy a device

on Amazon in order to be able to access the software system that the physician is using in order to interrogate their equipment.

That also translates into the bedside and at the facility level, if somebody comes in with a Medtronic or other manufacturer's device, we literally have to call in the technician to interrogate it before they have an MRI test, a Computed Tomography (CT) scan, all of those others, or even going for surgery. That causes a delay in treatment, a delay in overall length of stay, added healthcare costs, etc. I would like to see a more broadening of the communication of these patient reported outcome devices so that they are interoperable where the patient wants to share.

Elie Oliveira

Thank you. I love it. I think that somewhere in the recommendations there, we probably need to define maybe how we are going to determine it because I agree with both of you that there are a ton of patient reported outcome measures out there that are totally well established and validated. A promise is one that comes to mind that has a battery of assessments that can automatically be made available. That could be a place to start. If not, how do we get to a position where there is a discussion about those specific measures that needed to be made available fully in an interoperable way? We can get to that. It seems to me we have a good place to start here is that the problem is that patient generated data, whether it is from FDA approved devices or validated patient reported outcome measures are not incorporated in electronic medical records. That is a big gap in terms of providing care. I think we do not have a specific way. Maybe that is the challenge on how this can be done at scale. The opportunity is that we can maybe set up a specific standard or process and requirements by which EHR systems or other systems can integrate and deliver this result.

Anna, I am going to ask you to hold on that. We need to open to public comment and then come back to you. Accel team, I will turn it back to you.

Public Comments (01:14:59)

Tara Porter

Perfect. Thank you so much, Elie. At this time, we will now like to open up the meeting for public comment. If you are on Zoom and would like to make a comment, you can please use the hand raise function, which is located on the Zoom toolbar at the bottom of your screen. If you are dialed in on the phone only and would like to make a comment, you can press star nine to raise your hand and star six once called upon to unmute. We will give just a few seconds to see if anybody has any comments to make. I am not seeing any hands up or comments. Elie and Shila, I will turn it back to you. You have about nine minutes remaining to continue conversation. Thank you.

Elie Oliveira

Thank you, Tara. Anna?

Anna McCollister

Yes, I just wanted to quickly elevate what Ike has put in the chat. It is a very good point. A lot of trials these days are done digitally and remote, basically, making it easier on patients using mobile or iPad-based PROs and uploading the data to the CRO who is conducting the research. That has been an established practice for, I do not know, about 10 years. It gets more and more sophisticated as time goes on. It is a process that has been developed to be able to allow patients to write data into a system. There needs to be a way to incorporate that into the clinical record. It seems to me like we have got some places where we could go in terms of, I cannot remember the name of the organization that Craig Lipset started, focused specifically on digital clinical trials, but they have done, no doubt, a lot of work on this kind of stuff.

Elie Oliveira

Yes. I agree with that, Anna and Steve. Thank you for pointing that out. I think that is where I feel that we need to consider landscape scan of measures because I know of a few programs, again, I was talking about Patient-Reported Outcomes Measurement Information System (PROMIS) that is managed by Northwestern University, but it is funded by the NIH and has been an ongoing project for many years with a really large battery of well-established measures. I worked on another project on just early psychosis for young adults, and they had another set of assessments that they cover and so on and on. My point is are we going to recommend that we are going to maybe do that assessment scan of what are the measures that are well-established that could be standardized and be included and captured in some uniform way? Or that we are going to recommend maybe a specific set of

measures that we know that are already well-established in that and make recommendations on how to implement that in real settings going forward and based on the learnings, expand to others

That is just talking about PLOs, not the device-generated data. I think if we keep within FDA-regulated approved devices, that could be a good path as well. Other thoughts? We have got six minutes left.

Anna McCollister

One of the questions that I have about things like the PROMIS measures, and I learned this through many years of being on committees for National Quality Forum and CMS evaluating different measures, is that, apparently, a lot of groups make a lot of money by developing these measures. They charge copyright fees or licensing fees for the use of them. I do not know if that is part of the issue. If I, as a patient, choose to do a GAD-8 to monitor my anxiety through a mobile app, does that app then incur licensing fees or whatever? Do they have to pay for that? I do not know if that is part of the issue or what, but it is strange to me that these highly structured PROs are not something that can be incorporated into the EHR or viewed by the patient, the results over time if they are done through the interface, through the clinic, through the hospital system, whatever.

Eliel Oliveira

Yes. I am sure there is some of that as well, Anna. Some that are open, some that are not. I think that could be part of the assessment, too, to define maybe a starting point because if I remember correctly, I did a project with the ONC probably 10 years ago, and we defined the FHIR standard for questionnaire response was using PROMIS at the time. As far as I can remember, there was no issue using the measures. It was more about licensing their server because they are, I forgot the term that we use, but basically, depending on the answers or the questions, the next question we are going to change. In order to make that adjustment, it is basically talking to their servers to be able to define what is the next part of the questionnaire. That was a license cost you have to pay for to be able to be able to make those calls, but I think the measures themselves were not. Anyway, that is a great point of those measures for us to consider. Steve, I will turn it on to you. We have about four minutes left. I want to see what you have.

Steven Eichner

To bring things back around full circle, I think another aspect of patient-generated data is who that patient-generated data is supplied to and how is that data interoperable across the spectrum? I know I have participated personally in some clinical trials. I am not so sure that all the data that I have personally generated through that trial has ended up in both my clinical trial record and my regular clinical record. I know some of that data would be really useful, both clinically and research. Again, as a patient, I am not sure that it landed in both at the end of the day, so that might be something we could address as a potential gap coming around full circle about how is that data incorporated and how is that data returned or available to the patient in an interoperable format so that there is control in the ability to reuse that data or reshare that data.

Eliel Oliveira

Right. That is a tricky one, Steve. Knowing what I know about clinical trials and protocols and how the protocols have to be very specific, and if it was not defined in the protocol, it does not happen. I follow that very tightly, but it is still a good point. In some of these trials, depending on it, there are all types of studies and clinical trials where you really try a new compound, a new medication, and those are very risky. Not very risky, but depending on the condition, it could be very risky if you have a terminal cancer and the only hope is that trial. That is a different level of risk than a new trial for a new spring allergy medicine or a trial that is basically trying something less invasive. I think that it is a big complexity to address how study-specific results get incorporated in electronic medical records for clinical use. It is still an excellent point to add. Well, I think that we have done really well today, folks.

We addressed two out of, I believe, five of the lines, but at the same time, we covered a little bit of administrative aspects, like how this matrix is going to work, and how we are going to work through this. I think we did well that we can, in the next call, cover the other three or four lines on interoperability and keep making progress to the next area of discussion. If anyone has any other final thoughts to share, we are at 3:30, we are at time. Thank you so much for your comments today and participating, and I look forward to seeing you in a few weeks again.

Adjourn (01:24:39)

Questions and Comments Received Via Zoom Webinar Chat

Maggie Zeng: ONC 2024 Annual Report: https://healthit.gov/wp-content/uploads/2025/02/HITAC_Annual_Report_for_FY24_508.pdf

Anna McCollister to Everyone: Hi there - I was in transit and using zoom on my iPhone when you took roll call, and I couldn't figure out how to get off mute! Sorry about that! I'm now back at my office!

Hans Buitendijk: Regarding interest to use one's own system vs. sharing data across systems, isn't information blocking one of the "sticks" that addresses that, perhaps with its own gaps? While challenge programs with prices address capability gaps?

Steven Eichner: Each user type wants/deserves access to the data they want/need in the system/format they find most useful to them. aligns with Dr. Chiang's comments regarding different uses/different formats.

Hans Buitendijk: So a gap in ability to share images (column 1) we can enumerate lack of shareable links and funding for infrastructure would be in column 2.

Steven Eichner: Images can also be a complicated issue because of file sizes an understanding what quality image is needed for which purpose.

Eliei Oliveira: Multimodeal refers to the use of multiple modes, methods, or formats such as text, images, audio, video, and sensory data

Steven Eichner: Several years ago, I was able to get imaging done here in Texas to Philadelphia only because I knew what questions to ask of the imaging center up front.

Rochelle Prosser: Great point Steve

Michael Chiang: Proposed problem statement about "multimodal" data: inability to access to images and other data in raw data form in open standards (e.g., DICOM) with adequate metadata. Currently, data may be locked in proprietary formats.

Anna McCollister: Also... it's not just imaging data that gets locked in proprietary formats.. it's a lot of medical device data, including implantable defibrillators, insulin pump data (yes, still!), cardiac imaging, etc.

Michael Chiang: @Anna: completely agree that this goes beyond imaging...

Eliei Oliveira: +1

Rochelle Prosser: Wearable devices. Yes Anna

Steven Eichner to: Our solution: We set up an account for the physician in Pennsylvania with the facility's PACs system. That only worked because I had the physician's detailed information with me and knew to ask about the PACs. (and specifically went to the center because of their PACs. It should be easier.

Rochelle Prosser: Correct Eliei

Rochelle Prosser: Pediatric Moonshot comes to mind

Rochelle Prosser: Agree Michael. I do wonder if this would be viewed as punitive. Who suffers during the fallout period... the patient waiting for treatment

Michael Chiang to Everyone: @Rochelle: I agree with that concern, and it would be a challenging on-ramp to implement.

Steven Eichner to Everyone: Patient-reported data is often use in research trials, using a variety of technologies and modalities, raging from monitoring devices to tablets or applications for data collection.

Steven Eichner to Everyone: correcting a typo: "use" should have been "used"

Questions and Comments Received Via Email

No comments were received via email.

Resources

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Transcript approved by Tara Porter, HITAC DFO, on May 21, 2026.