

**LYMPHOMA
COALITION** 



HTA SIG Workshop

24 October 2024 | Rome, Italy

AGENDA

Agenda Item	Description	Time
Welcome	Introduction to the agenda, workshop aims and objectives.	10 minutes
Research Analysis	Autologous transplant vs. CAR-T therapy in patients with DLBCL treated while in complete remission. <ol style="list-style-type: none">1. What constitutes good research?2. What is decision-grade evidence, and what is not?3. How to interpret complex data sets and results.	40 minutes
Break		15 minutes
Case Study	Comparison of HTA appraisals from NICE (UK) and the CDA-AMC (Canada). <ul style="list-style-type: none">• NICE and CDA-AMC (formerly CADTH) assessment reports: cost-effectiveness analysis and patient submissions for the bispecific glofitamab, brand name Columvi.• Real-World Evidence	45 minutes 20 minutes
AI in HTA	AI in HTA processes and considerations for the future.	20 minutes
Planning	Key priorities, interests and HTA SIG Member needs to support patient involvement in HTA.	15 minutes
Closing comments	Group reflections and next steps.	15 minutes

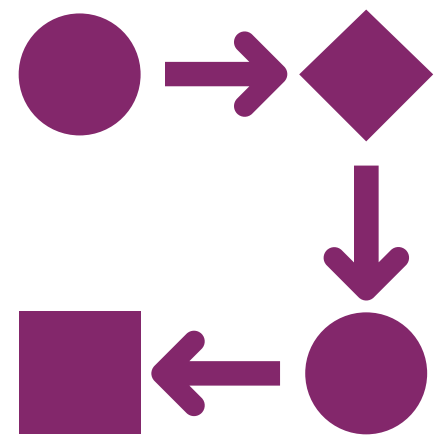


RESEARCH ARTICLE ANALYSIS

Autologous transplant vs. CAR-T therapy in patients with DLBCL treated while in complete remission

GENERAL FORMAT OF A RESEARCH ARTICLE

Generally, research articles follow a similar structure and typically contain the following sections:



- **Abstract** – brief summary of the study's findings
- **Introduction/Background** – background information and aim of the study
- **Methods** – includes patients, the study design, the materials that were used, and the study procedure
- **Results** – key findings of the study
- **Discussion** – relevance of study results, limitations
- **Conclusion** – summary of findings

INITIAL QUESTIONS

What were your initial thoughts after reading the study?

Was it easy to understand?

What was difficult to comprehend?

KEY HIGHLIGHTS



Background information

- In areas with access, CAR-T therapy is becoming the standard of care for patients with relapsed/refractory large B-cell lymphomas
- Previous studies have shown a survival benefit with CAR-T vs. autologous stem cell transplant (auto-sct), however, those with a complete response from therapy prior to either treatment has not been fully explored
- Aim of this study was to compare outcomes of these two treatments in patients in complete remission from their previous therapy

KEY HIGHLIGHTS



Study Methods

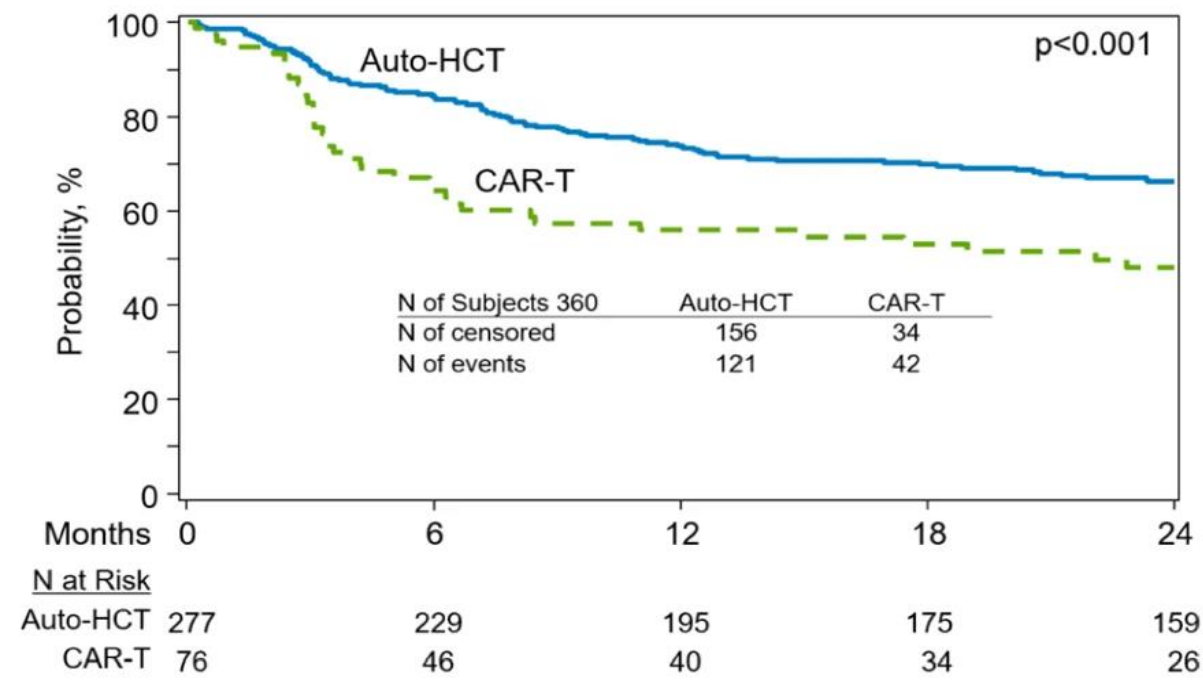
- Retrospective, observational study – data from Center for International Blood and Marrow Transplant Research (CIBMTR) database
- Included patients aged 18-75 with large cell lymphomas – including DLBCL, primary mediastinal B-cell, double/triple hit lymphomas who received either auto-sct or CAR-T
- Auto-sct treated between 2015-2021, CAR-T between 2018-2021
- Primary endpoints – progression free survival (PFS) and overall survival (OS)
- 360 patients included in the study, 281 treated with auto-sct, 79 with CAR-T

PATIENT CHARACTERISTICS

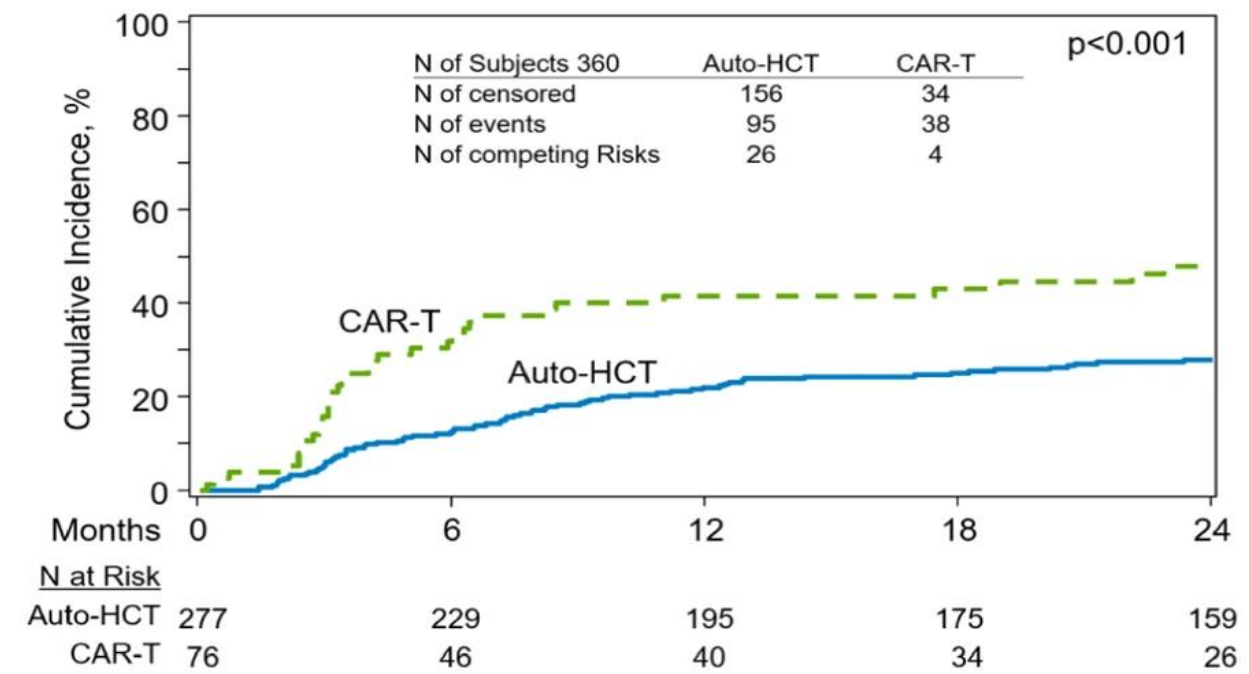
Characteristic	Auto-SCT (n = 281)	CAR-T (n = 79)
Age		
Median (min-max)	59.4 (18.2-75.6)	64.1 (20.1-76.0)
>65 - no. (%)	92 (32.7)	35 (44.3)
High-grade B-cell lymphoma, with MYC and BCL2 and/or BCL6 rearrangements - no. (%)		
Yes	31 (27.0)	11 (13.9)
No	84 (73.0)	68 (86.1)
Early therapy failure in 12 months - no. (%)	163 (58.0)	57 (72.2)
Total lines of therapies - median (min-max)	2.0 (2.0-8.0)	3.0 (2.0-8.0)
Year of auto-SCT/CAR-T - no. (%)		
2018 and after	114 (40.5)	79 (100)

VARIOUS SURVIVAL, PROGRESSION AND MORTALITY RATES

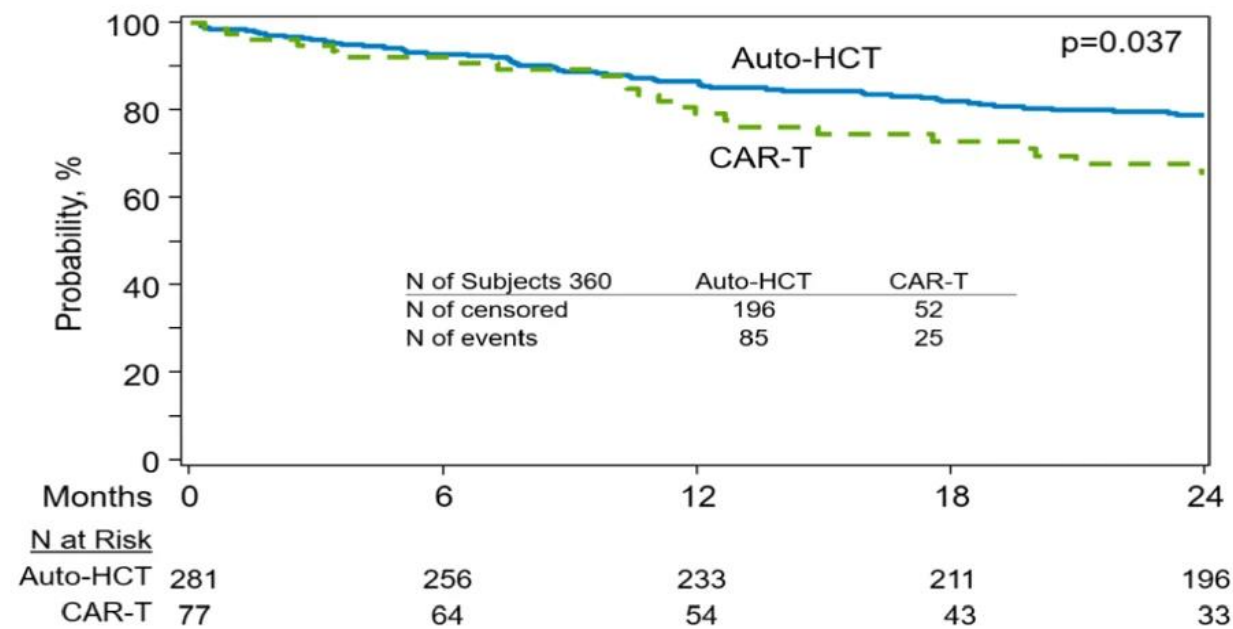
A Progression-free Survival



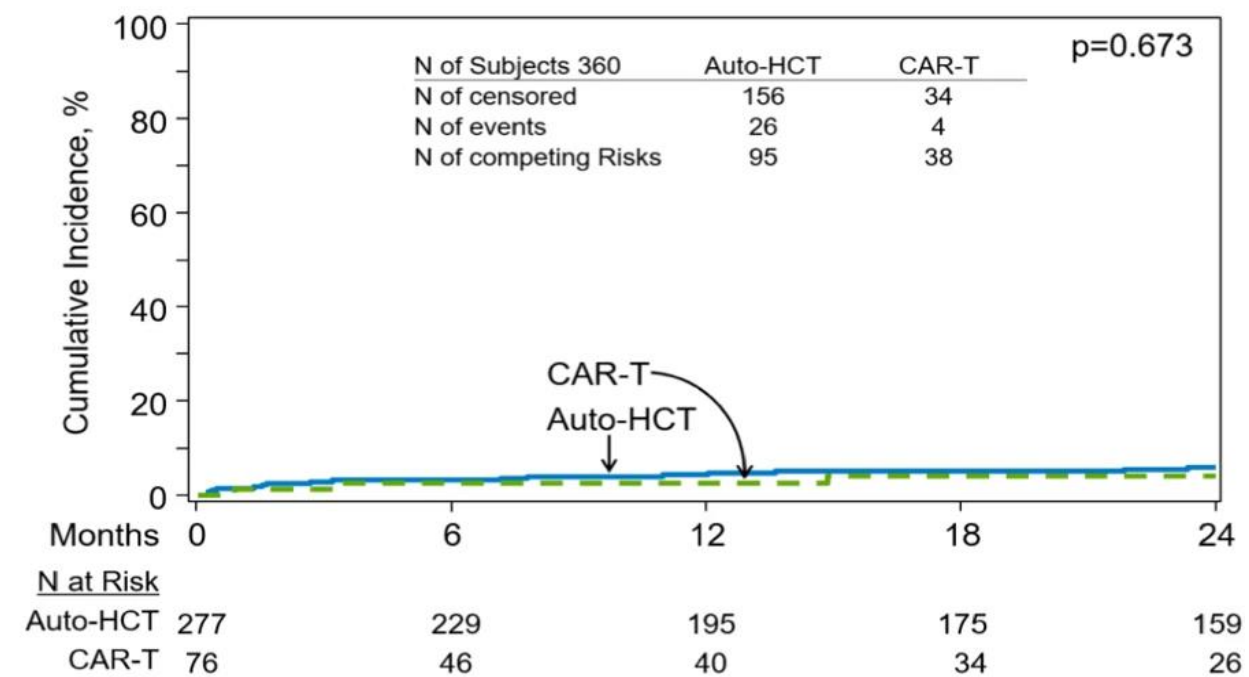
B Relapse/Progression



C Overall Survival



D Non-Relapse Mortality



ANALYSIS OF OUTCOMES

Outcome	Auto-SCT (n=277)	CAR-T (n=76)
Non-relapse mortality		
1-year	4.4% (2.3-7.1)	2.6% (0.2-7.4)
2-year	5.9% (3.4-9.1)	4.1% (0.8-10)
Relapse/progression		
1-year	21.9% (17.2-27)	41.6% (30.6-53.1)
2-year	27.8% (22.6-33.4)	48% (36.4-59.7)
Progression-free survival		
1-year	73.7% (68.3-78.8)	55.7% (44.4-66.8)
2-year	66.2% (60.4-71.8)	47.8% (36.4-59.4)
Overall survival		
1-year	86.7% (82.4-90.4)	79.1% (69-87.7)
2-year	78.9% (73.9-83.6)	65.6% (53.6-76.6)

OUTCOMES IN PATIENTS WHO RELAPSED WITHIN 12 MONTHS OF FIRST-LINE TREATMENT

	Auto-SCT (n=179)	CAR-T (n=60)
Non-relapse mortality		
1-year	5.6% (2.7–9.5)	3.3% (0.3–9.4)
2-year	6.8% (3.6–11)	5.3% (1–12.7)
Relapse/progression		
1-year	21.9% (16.1–28.3)	46.3% (33.5–59.3)
2-year	25% (18.8–31.7)	46.3% (33.5–59.3)
Progression-free survival		
1-year	72.5% (65.7–78.8)	50.4% (37.6–63.1)
2-year	68.2% (61.1–74.9)	48.4% (35.7–61.3)
Overall survival		
1-year	84.4% (78.7–89.3)	78.8% (67.2–88.4)
2-year	79.6% (73.3–85.2)	66.3% (53–78.4)

MULTIVARIABLE ANALYSIS OF OUTCOMES

Outcomes	No. Patients	Hazard Ratio	95% CI Lower	95% CI Upper	P-Value
Non-relapse mortality					
Age					
41–65	194	1.11	0.14	9.06	<0.0001
>65	127	6.41	0.85	48.24	<0.0001
Relapse/progression					
Auto-SCT	277	1			<0.0001
CAR-T	77	2.18	1.48	3.2	<0.0001
Progression-free survival					
Age					
41–65		1.3	0.67	2.52	<0.0001
>65		1.99	1.03	3.86	<0.0001
Auto-SCT	277	1			0.0011
CAR-T	77	1.83	1.27	2.63	0.0011
Overall survival					
Age					
41–65	197	1.19	0.51	2.79	0.0002
>65	127	2.56	1.1	5.95	0.0002
Auto-SCT	281	1			0.1234
CAR-T	77	1.44	0.91	2.28	0.1234

KEY HIGHLIGHTS



Other Notable Results

- 68% of patients developed cytokine release syndrome (CRS) with 2.6% having grade 3 or 4 and 32% developed neurotoxicity syndrome (ICANS)
- During study follow up 30% auto-sct and 32% CAR-T patients died
- Most common causes of death – disease progression (60% auto-sct, 68% CAR-T), infections (15% auto-sct, 8% CAR-T)

KEY HIGHLIGHTS



Discussion/Limitations

- Authors suggest a role for auto-sct in patients whom chemoimmunotherapy still works
- Clinical trials for CAR-T approvals did not isolate patients who were still sensitive to chemoimmunotherapy
- Study Limitations
 - Retrospective analysis – using data from the past, possible cofounders present
 - Authors note a randomised controlled trial between the 2 groups would be ideal

WRAP UP DISCUSSION

What are your thoughts after completing this exercise?

Can a study such as this add value to HTA?

Do you feel this qualifies as “good research”? Why or why not?





CASE STUDY

Comparison of Cost-Effectiveness and Patient Submissions from two HTA Assessment Reports

OBJECTIVES



Find 2 HTA bodies that are considered efficient, take similar approaches in cost analyses and have processes for patient input into assessments

- United Kingdom and Canada



Compare the similarities and differences between assessment reports using a real-world example



Focus on cost-effective analysis and patient submissions for glofitamab (Columvi) indicated for DLBCL patients following 2 or more relapses

INTRODUCTION

ORGANISATIONS RESPONSIBLE FOR HTA ASSESSMENTS/RECOMMENDATIONS

United Kingdom



Canada

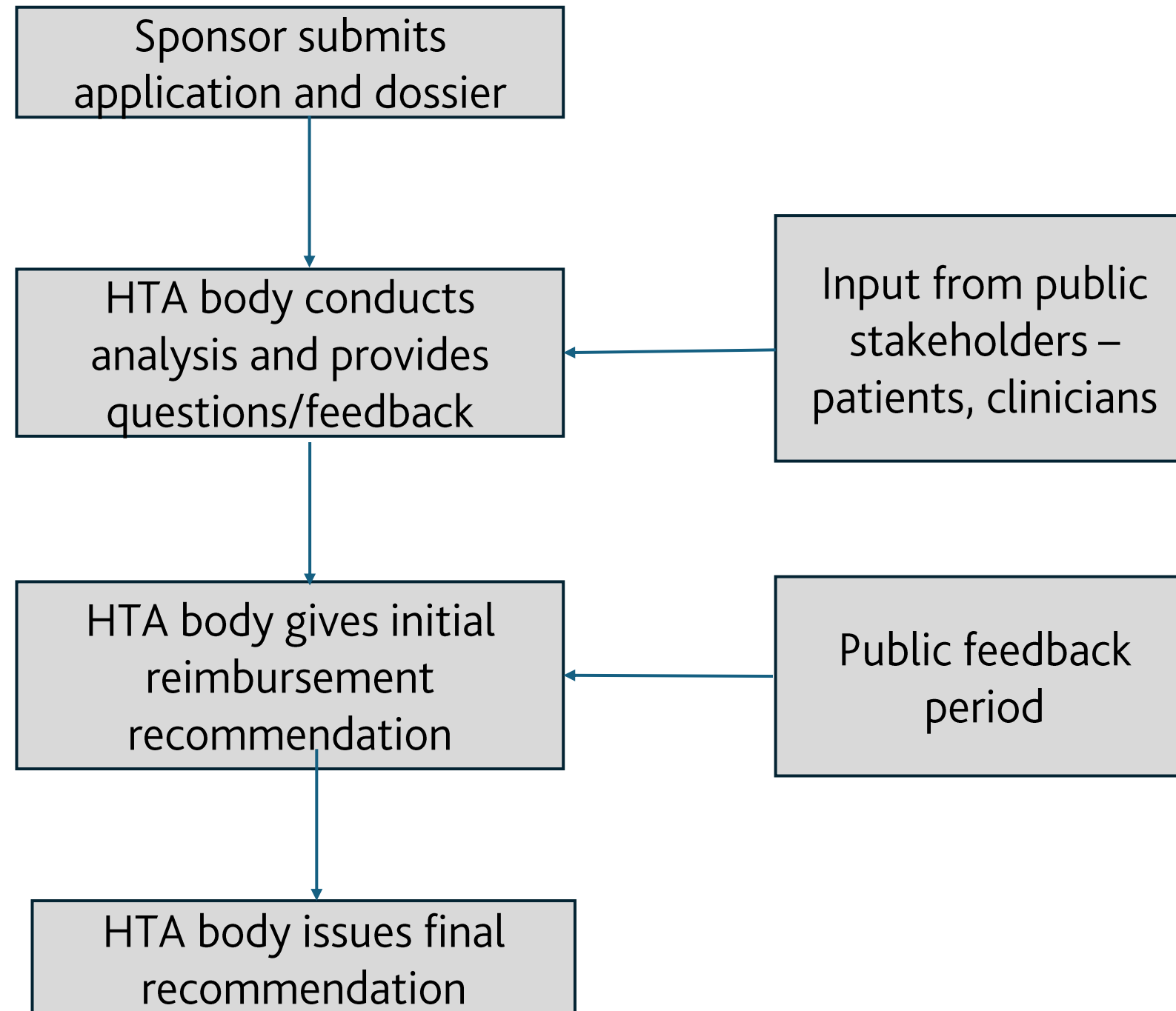


Canada's Drug Agency
L'Agence des médicaments du Canada
Drugs. Health Technologies and Systems. Médicaments, technologies de la santé et systèmes.

HTA PROCESSES

NICE
recommendations
are binding

CDA
recommendations
are non-binding



Overall, both agencies have similar HTA processes.

COST-EFFECTIVENESS ANALYSIS

Two calculations commonly used in cost analysis.

- Quality-adjusted life year (QALY) - attempt to quantify health-related quality of life and calculate the additional number of years a person lives as a result of receiving a treatment, while taking into account the quality of life in those years
 - $QALY = \text{Life Expectancy (years)} \times \text{Health-Related Quality of Life (HRQoL) measurement}$
 - Where HRQoL measurement is between 1 (perfect health) and 0 (death)
- Incremental cost-effectiveness ratio (ICER) - an estimate of the additional cost for one additional unit of health outcome (QALY)

$$ICER = \frac{Cost_{Exp} - Cost_{Con}}{QALY_{Exp} - QALY_{Con}}$$

Inputs considered for cost-effective analysis.

- Cost of investigative drug and comparators
- Costs of additional treatment – supportive care medication, conditioning therapies
- Administration costs – infusion costs, adverse events, pharmacy costs

COST-EFFECTIVENESS ANALYSIS

NICE (United Kingdom)

- Comparators used for cost analysis
 - Polatuzumab Vedotin + Rituximab + Bendamustine, CAR-T Axicabtagene Ciloleucel
- Breakdown of cost inputs are more detailed
- Cost effectiveness threshold - £20,000 per QALY
- Due to confidential discount pricing agreements, much of the cost analysis redacted

CDA (Canada)

- Comparators used for cost analysis
 - Rituximab based chemoimmunotherapy, Polatuzumab Vedotin + Rituximab + Bendamustine
- Cost analysis summarised, input details not published
- Cost effectiveness threshold - \$50,000 per QALY
- Assessment report is more concise and easier to interpret

PATIENT SUBMISSIONS

- Patient submissions are facilitated through a patient organisation
- A standard template is used for submitting patient feedback

NICE (United Kingdom)

- Template for patient feedback is more open ended with general topics to provide commentary
- Patient submission facilitated by Lymphoma Action
- Conducted an online questionnaire received 3 responses

CDA (Canada)

- Template for patient feedback has specific questions to answer
- Patient submission facilitated by Lymphoma Canada
- Conducted an online survey received 27 responses, 2 who had previously received glofitamab and 8 who were residents of Canada

DISCUSSION QUESTIONS

Given these observations, what are your thoughts?

What are potential action items for future meetings

How much impact do you feel patient feedback has in the final recommendation?



Which template do you feel is more effective?

What are your thoughts on the overall HTA process?





**AN EXAMINATION OF THE USE OF
REAL-WORLD EVIDENCE IN HTA:
UNITED KINGDOM AND CANADA**

	Real-World Data (RWD)	Real-World Evidence (RWE)
	<p>Data relating to patient health, experience or care delivery collected outside of clinical trials from a variety of sources, such as registries, patient health records, administrative records, surveys, observational cohort studies, and more.</p>	<p>Clinical evidence generated from the analysis of RWD, including the usage and potential benefits or risks of a product derived from analysis of RWD, covering evidence such as disease epidemiology and research.</p>
	<p>Limitations: potential bias, transparency, debates about when RWD is deemed “good enough”, lack of clarity over data governance, and more.</p>	<p>Limitations: mistrust, inconsistencies, insufficient information, data quality, skepticism about the value, and more.</p>

[Using Real-World Data in the Health Technology Assessment of Pharmaceuticals: Strengths, Difficulties, and a Pragmatic Way Forward - ScienceDirect](#)

INSIGHTS ON THE USE OF RWD/RWE

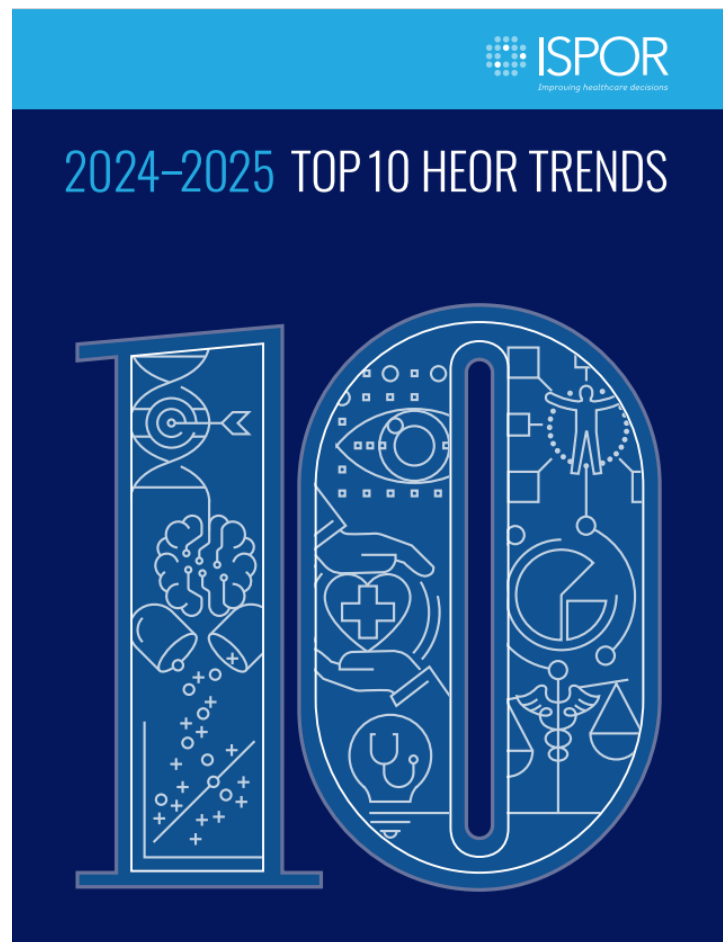


- In HTA systems and processes, similarities and differences exist across countries and regions.
- Some countries do not have RWE guidelines in place – for instance, Poland, Germany, and Singapore.
- Several countries are currently exploring the importance of RWD and RWE, such as Denmark, Japan, Sweden and Switzerland.

China	Italy	Korea	The Netherlands	United States
Follows guidelines for the use of RWE in drug research and development.	Values RWE as insights into drug usage, patient characteristics and patient safety.	Provides a national database that serves as a comprehensive source of RWD.	Accepts RWD in assessing clinical effectiveness, alongside randomised controlled trial data as primary evidence.	Uses a framework for RWE to help generate data to support new indications and post-approval requirements.

RWE TRENDING #1 | TOP ISPOR HEOR TRENDS

“Real-World evidence has become real as it starts to play a very tangible role in healthcare decision making.”



- ISPOR identifies RWE as the #1 trend
- FDA, EMA, NICE, CDA – all released guidance on different aspects of RWE generation.
- Key considerations: data quality, fit-for-purpose use, and registry data.
- **Transparency of processes are a key area of focus for many, including ISPOR.**

EXPANSION OF RWE IN THE HTA LANDSCAPE



Medical Product Development	Regulatory Review	Care Delivery	Payment, Pricing and Coverage
<ul style="list-style-type: none"> • Informs understanding of disease • Identifies unmet needs 	<ul style="list-style-type: none"> • Informs post-market and pre-market safety • Informs new approvals • Informs indication and labelling decisions 	<ul style="list-style-type: none"> • Supports patients' engagement in care decisions • Drives higher-value care 	<ul style="list-style-type: none"> • Aligns regulators, payers and HTA bodies • Addresses payments for high-cost treatments • Increases access

RWE GUIDANCE AND PRACTICES

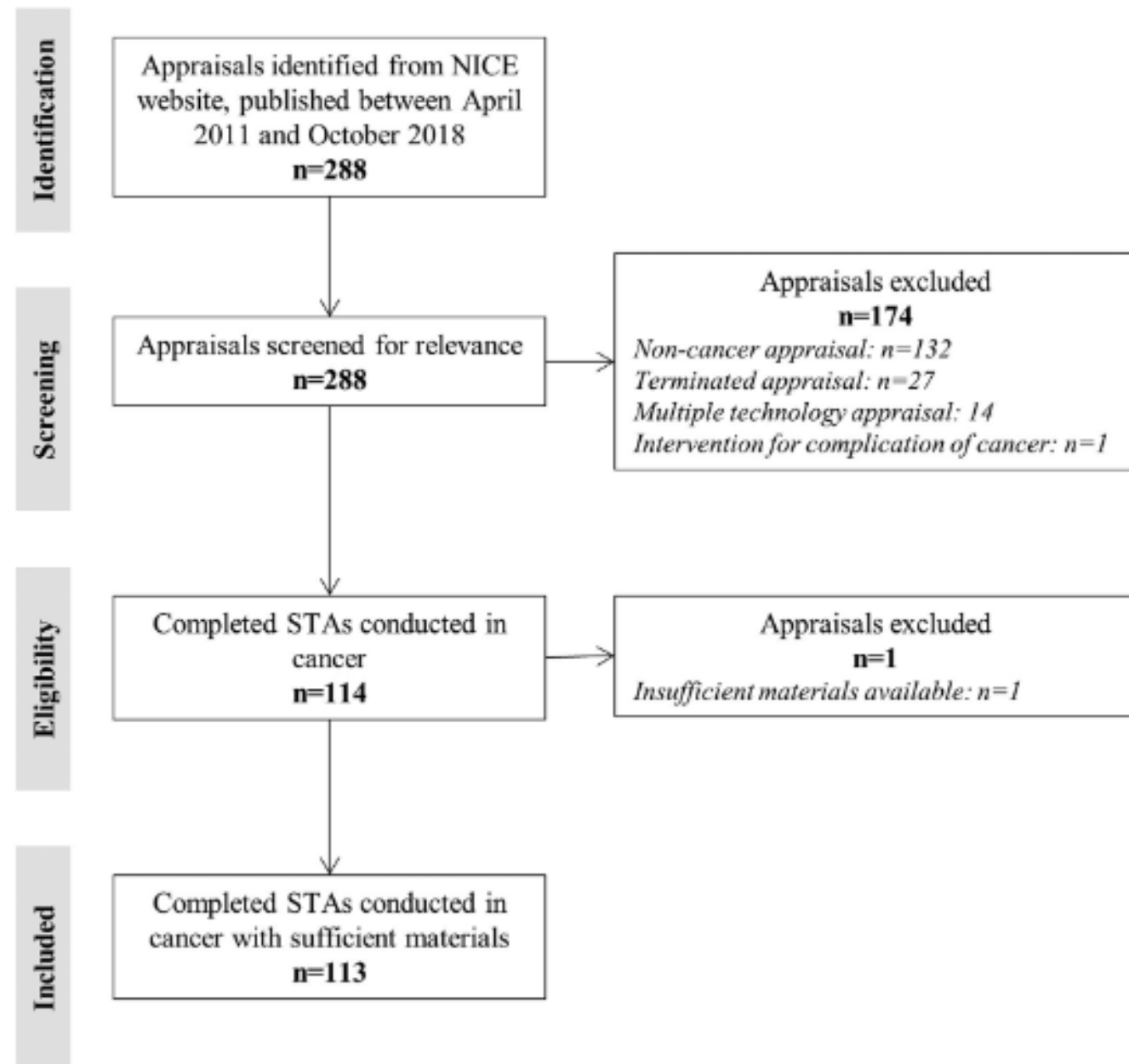
NICE (UNITED KINGDOM)

- Uses RWD that represents the population as **preferred source for evidence**.
- Developed a *framework* that targets those developing evidence and aims to **improve the quality of RWE** to inform guidance.
- Integrated RWD into the NICE Strategy (2021-2026) to **resolve gaps in knowledge and drive access to innovation** for patients.
- Broadly, considers single-arm trials that use RWD to create an external control as RWE studies.

CDA (CANADA)

- Partnered with Health Canada and others to advance the integration of RWE into decision-making.
- Produced the **Guidance for Reporting Real-World Evidence** (May 2023) to help define the use of RWE in regulatory approval and HTA processes.
- Guideline establishes a foundation for the **use of RWE in regulatory approval and HTA, beginning with the principles for transparent reporting of RWE studies**.
- Uses a *Recommendations Checklist* tool.

RWE IN HTA SUBMISSIONS AND DECISIONS (UK)



EARLY DAYS:

Between **2011 to 2018**, there were **113 relevant single technology appraisals** that evaluated cancer treatments in the UK. One appraisal was excluded due to insufficient materials.

- ❖ 96% of those 113 STAs included some form of RWE within the company submitted cost-effectiveness analysis.
- ❖ The most common RWE categories were health related quality-of-life (71%); costs (46%) and medical resource utilisation (40%).
- ❖ NICE accepted most RWE for cancer drug submissions.

HTA Case Studies Comparing Acceptability of RWE in Appraisals for Oncology Medicines

- Funded by Bayer Healthcare Pharmaceuticals
- Identified oncology medicines with final reports that contained RWE
- Six oncology medicines reviewed as case studies for comparative assessment of RWE acceptability with two for indications in lymphoma

January-December 2022	NICE UK	G-BA GERMANY	HAS FRANCE
Number of appraisals for oncology medicines	37	36	34
RWE referenced in appraisals (<i>*Based on final appraisals for oncology medicines across three HTA bodies</i>)	43.2% (16 of 37)	35.9% (14 of 39)	29.4% (10 of 34)

Drug Name and Disease Indication	RWE Approach	RWE Acceptability	Bias	HTA Outcome
Axicabtagene-ciloleucel (Yescarta) (follicular lymphoma and DLBCL)	Indirect comparison	Not adequate	HAS: Study design bias; quality design bias; outcome bias; analysis bias G-BA: Data quality bias; selection bias; analysis bias	No clinical added value Non-qualifiable additional benefit
Tisagenlecleucel (Kymriah) (follicular lymphoma)	Indirect comparison	Not adequate	HAS: Data quality bias; outcome bias; analysis bias G-BA: Data quality bias; selection bias; analysis bias	No clinical added value Non-qualifiable additional benefit

Study Conclusions:

- Discrepancy in assessment of RWE by the 3 HTA agencies
- Comprehensive guidelines needed to standardise best practices for RWE assessments
- HAS and G-BA emphasis: data quality, selection biases, and confounding factors related to RWE use



HTA guidance updates and usage of RWE in reimbursement decisions – A 2023 perspective

- Funded by Parexel
- Research objective - identify HTA guidance on use of RWE and analyse trends in reimbursement decisions involving RWE

Overall use of RWE in HTA submissions

- NICE: 32% (12/38)
- CDA: 58% (19/33)

Received positive outcomes from agencies

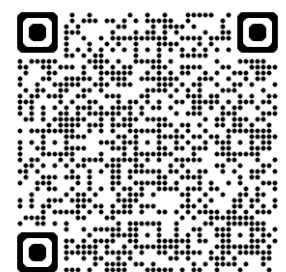
- NICE: 75% (9/12)
- CDA: 95% (18/19)

	Submissions	Oncology	Blood and immune	Others	All disease areas
NICE (UK)	Total number of records	13	10	15	38
	Number of records with RWE	3	4	5	12
	Positive recommendations for RWE	3	2	4	9
CDA (Canada)	Total number of records	8	10	15	33
	Number of records with RWE	8	7	3	19
	Positive recommendations for RWE	8	7	2	18

Others defined as metabolic, digestive, kidney, neurological, respiratory, musculoskeletal, and neurodevelopmental conditions

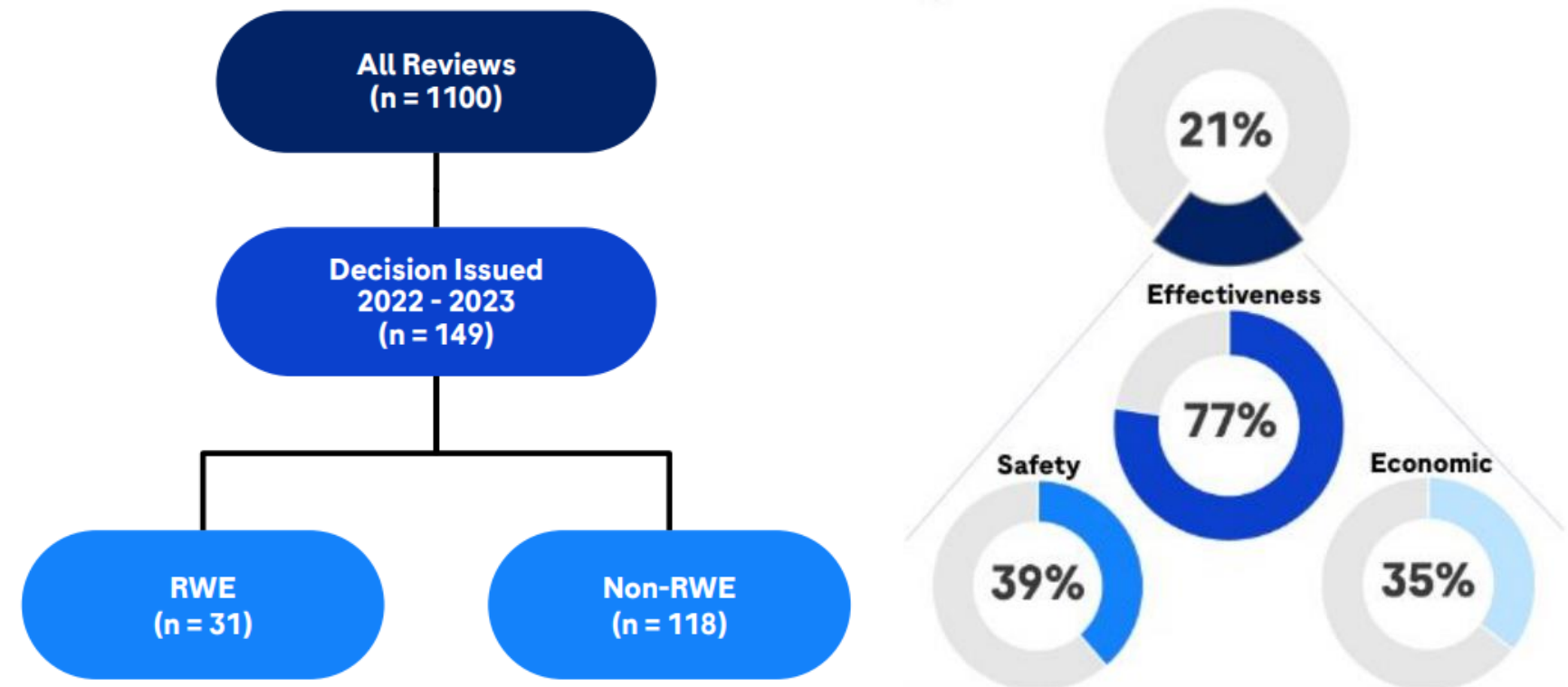
Study Conclusions:

- RWE usage in HTA submissions is increasing
- More availability of guidance on best practices for planning, conducting and reporting of RWE
- Collaboration and engagement between HTA agencies and industry warranted



Reception of RWE: Trends in CDA Reimbursement Reviews (Canada | 2022-2023)

- Produced by Hoffman-La Roche Limited
- To explore trends among RWE usage and appraisal in reimbursement reviews in Canada
- Focus on all CDA reimbursement reviews with recommendations from 2022-2023



Results:

- 21% (or 31 of 149) reviews included RWE
- Patient registries and medical records provided RWE for 94% of reviews
- 61% RWE reviews were for oncology drugs
- Positive recommendation was issued in 74% of RWE reviews

Highlights and Conclusions:

- RWE evaluated by CDA in approximately 1 in 5 reviews, with higher average review time (266 days) than non-RWE (254 days)
- Association between reviews with evaluated RWE and positive recommendation not statistically significant
- Files with RWE as pivotal evidence had a lower positive recommendation rate than those where RWE was supplementary
- RWE prevalent in CDA reimbursement reviews, typically in support of effectiveness

DISCUSSION QUESTION

Do you think that RWE adds value to HTA?

If yes, how?

If no, why not?



DISCUSSION QUESTIONS

Should patient organisations be further leveraging RWE to address knowledge gaps in the assessment of new technologies?

How concerning are biases in HTA appraisals with RWE and what can patient organisations do about them?

How are HTA bodies *really* doing in terms of integrating RWE into HTA decision-making

How can we help RWE gain more momentum and greater profile in HTA processes?





ARTIFICIAL INTELLIGENCE IN HTA



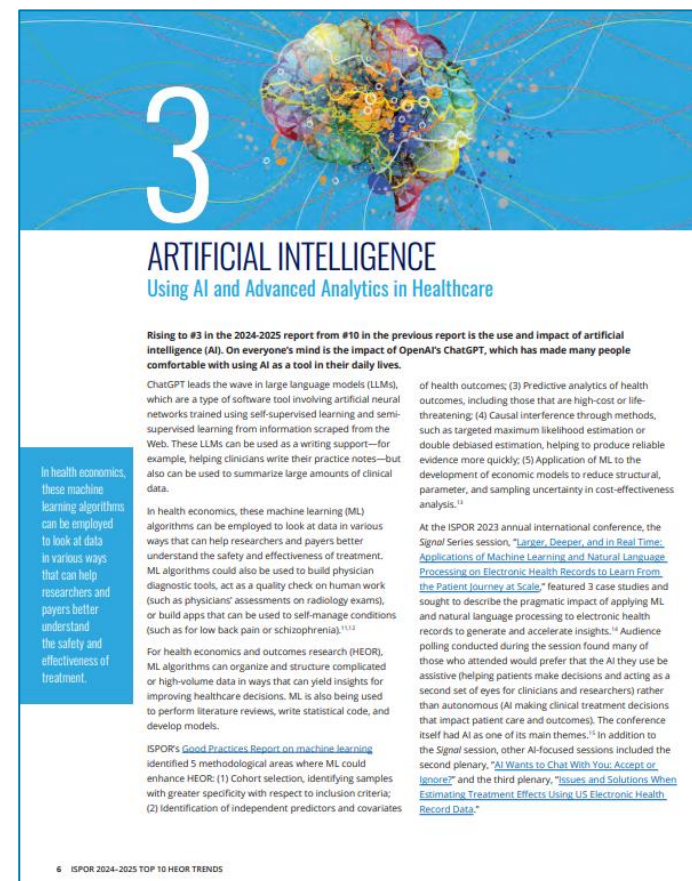
“It's highly likely that, in the near future, evidence considered by NICE will be informed by AI methods.

However, concerns about the appropriateness, transparency and trustworthiness of AI do exist.”

NICE Position Statement on AI

AI TRENDING #3 | TOP ISPOR HEOR TRENDS

Health economics and outcomes research (HEOR) algorithms can “organise and structure complicated or high-volume data in ways that can yield insights for improving healthcare decisions.”



- ISPOR identifies AI as the #3 trend (2024-2025)
- AI rose rapidly from #10 spot in the previous report to where it is now

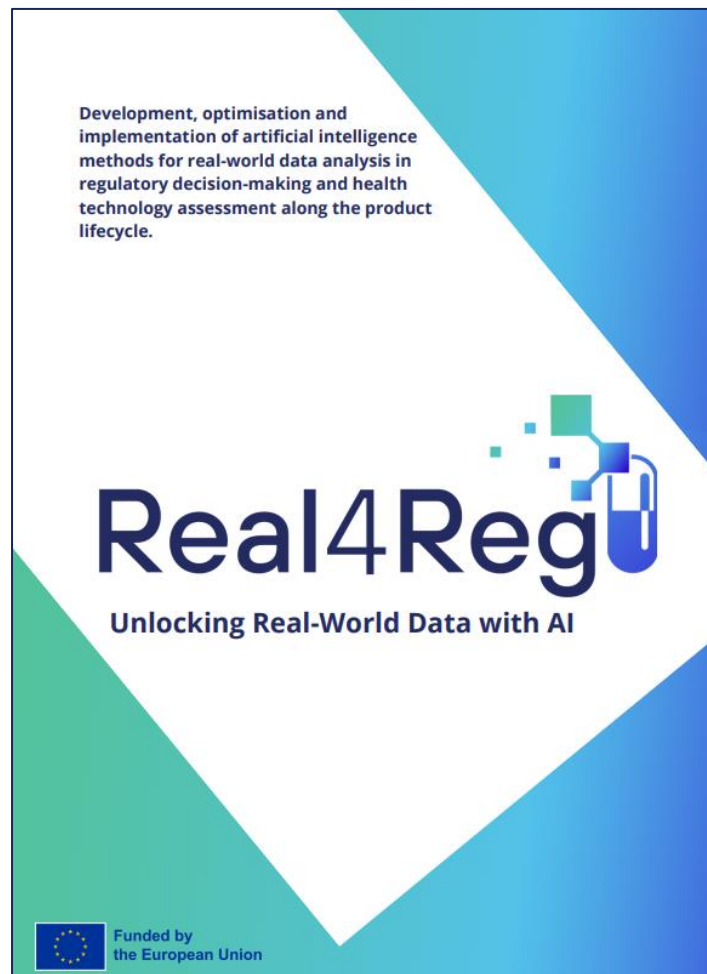
ETHICS AND GOVERNANCE FOR AI IN HEALTH

“Our future is a race between the growing power of technology and the wisdom with which we use it.” Stephen Hawking

- To advance patient interests, **AI needs ethical design**
- Requires health systems to **avoid encoding biases** that are detrimental to access and care
- According to the WHO, key factors include:
 - Ensuring transparency, explainability and intelligibility
 - Fostering responsibility and accountability
 - Ensuring inclusiveness and equity
 - Promoting AI that is responsive and sustainable



AI and RWD – IN PRACTICE, NOT PLANNING



[Unlocking Real-World Data with AI - Real4Reg](#)

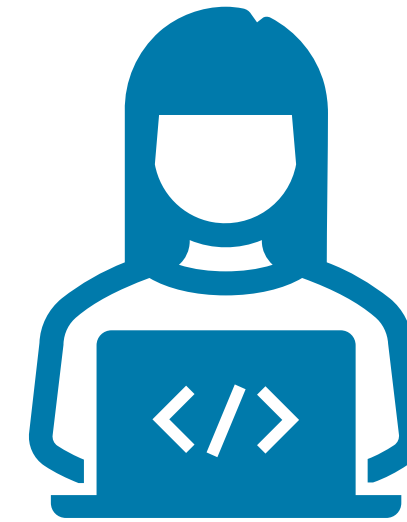
- Funded by the European Union, **Real4Reg** is a consortium of ten European institutions from six countries.
- Their aim is to promote the use of real-world data (national healthcare registers and claims data) to support the regulatory decisions about medicines.
- The work uses ground-breaking technologies such as artificial intelligence and machine learning to facilitate the implementation of the effective use of real-world data in regulatory decision-making and health technology assessment.

Data sources come from Denmark, Finland, Germany, and Portugal to help develop solutions to address the data analytical needs of regulatory agencies.

Aligned with the decision-making process in regulatory agencies - pre-authorisation, evaluation, and post-authorisation phases of the product lifecycle.

“Hello, CoPilot...Are you there?”

1. How will AI help patient submissions in HTA?
2. **What are the challenges of using AI in HTA?**
3. How can bias in AI be mitigated?
4. **How can patient groups benefit from AI in HTA submissions for new drugs?**
5. How can AI help capture real-world evidence?
6. What HTA agencies are currently using AI for HTA decision-making processes?
7. Are patient groups in Europe using or exploring AI for HTA submissions? If yes, how?
8. Tell me more about patient involvement in AI-driven HTA?
9. Tell me more about current projects that explore the integration of AI in HTA?



Hello, CoPilot...

What are the challenges of using AI in HTA?

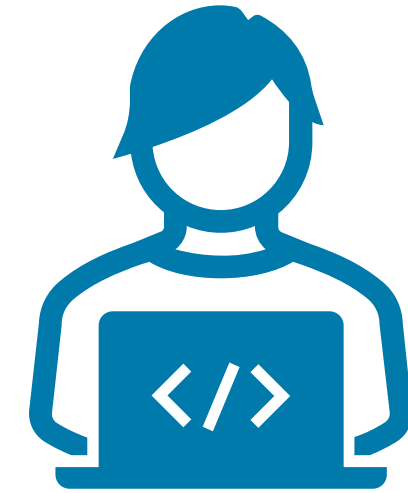
What are the challenges of using AI in HTA?



Using AI in Health Technology Assessment (HTA) presents several challenges:

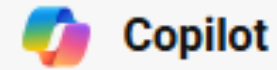
1. **Data Quality and Availability:** AI systems require large amounts of high-quality data to function effectively. In many cases, the necessary data may be incomplete, inconsistent, or inaccessible¹.
2. **Transparency and Interpretability:** AI models, especially complex ones like deep learning, can be difficult to interpret. This lack of transparency can make it challenging for decision-makers to trust and understand the AI's recommendations¹.
3. **Regulatory and Ethical Concerns:** Handling sensitive health data involves strict regulatory compliance. Ensuring patient privacy and data security while using AI is a significant challenge².
4. **Integration with Existing Systems:** Incorporating AI into existing healthcare systems and workflows can be complex and resource-intensive. It requires significant changes in infrastructure and processes².
5. **Limited Awareness and Acceptance:** There is often limited awareness and openness among decision-makers regarding the potential of AI. This can hinder the adoption and integration of AI-driven evidence in HTA³.
6. **Continuous Evolution of AI:** AI technologies evolve rapidly, which can complicate the timing and approach for HTA evaluations. Keeping up with these advancements and ensuring that assessments remain relevant is a continuous challenge⁴.

Hello, CoPilot...



How can patient groups benefit from AI in HTA submissions for new drugs?

How can patient groups benefit from AI in HTA submissions for new drugs?



Patient groups can significantly benefit from the use of AI in Health Technology Assessment (HTA) submissions for new drugs in several ways:

1. **Enhanced Data Analysis:** AI can process and analyze large datasets more efficiently than traditional methods. This allows for a more comprehensive evaluation of patient outcomes and treatment effectiveness, providing stronger evidence to support HTA submissions ¹.
2. **Improved Patient Representation:** AI can help identify and include diverse patient populations in the analysis, ensuring that the HTA submissions reflect the experiences and needs of a broader range of patients ². This can lead to more equitable healthcare decisions.
3. **Faster Decision-Making:** By automating data processing and analysis, AI can speed up the HTA process. This means that new drugs can be assessed and potentially approved more quickly, giving patients faster access to innovative treatments ¹.
4. **Better Predictive Models:** AI can create more accurate predictive models for patient outcomes, which can be used to demonstrate the potential benefits and cost-effectiveness of new drugs. This can strengthen the case for their approval and reimbursement ².
5. **Enhanced Communication:** AI tools can help patient groups better communicate their needs and experiences to HTA bodies. For example, natural language processing (NLP) can be used to analyze patient feedback and summarize key points in a clear and concise manner ³.
6. **Increased Transparency:** AI can improve the transparency of the HTA process by providing clear and interpretable results. This can help patient groups understand how decisions are made and advocate more effectively for their needs ¹.

Geoffrey E. Hinton, University of Toronto, Canada
2024 Nobel Laureate in Physics

October 08, 2024



“Whenever I want to know the answer to anything, I just and ask GPT4.”

“Instead of exceeding people in physical strength, it’s going to exceed people in intellectual ability.”

“The rise of AI is going to be wonderful in many respects, but we also have to worry about a number of possible bad consequences, particularly the threat of these things getting out of control.”

DISCUSSION QUESTIONS

Is there a place for AI in HTA processes?

If yes, where?

If no, why not?

What are the risks or benefits of using AI in HTA?

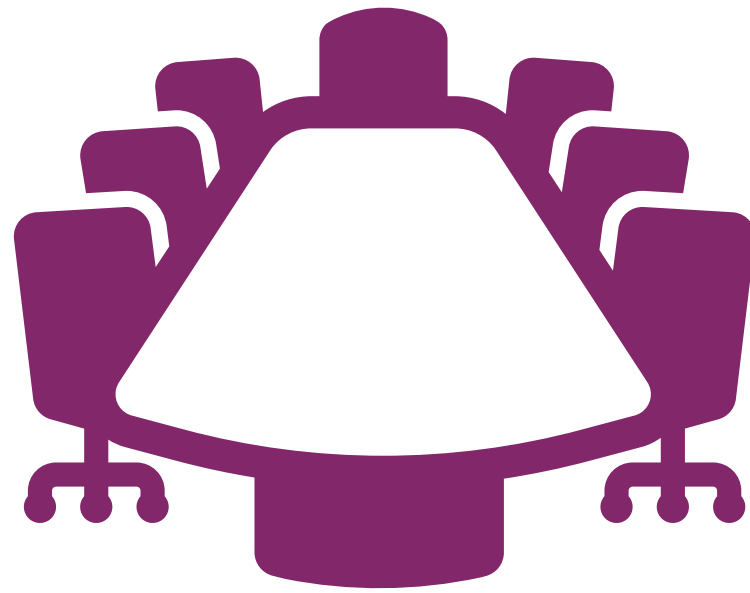
What role can patient organisations play in helping to safely integrate AI in HTA?

What does a formal augmented AI pathway look like for HTA patient submissions?

If you are using AI, how are you using it to support patient involvement in HTA processes?

What does an ethical approach for the use of AI look like? How do we get there?





CLOSING COMMENTS and REFLECTIONS
NEXT STEPS

Thank you!