

## MINUTES

Health Technology Assessment Subcommittee  
Wilsonville Training Center  
29353 SW Town Center Loop E, Wilsonville, Oregon 97070  
April 22, 2013  
1:00-4:00pm

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**Members Present:** Alissa Craft, DO, MBA; Gerald Ahmann, MD (by phone); James MacKay, MD; Timothy Keenen, MD (arrived 1:10 pm); George Waldmann, MD (arrived 1:20 pm, left at 4:00 pm);.

**Members Absent:** None.

**Staff Present:** Darren Coffman; Wally Shaffer, MD, MPH; Jason Gingerich.

**Also Attending:** Alison Little, MD (CEBP); Shannon Vandergriff (CEBP); Joanie Cosgrove (Medtronic); Paul Radensky (McDermot, Will & Emery/Roche); Kathy Kirk (Oregon Pain Management Commission), Ralph P. Eccles (OHSU), Jim Hoover (Bayer), Jason Parks (ACSCAN), Andrew Ahmann (OHSU), Cheryl A. Moore (ODE/AADE), Jim Clark (Roche Diagnostics), Farahnaz Joarder (OHSU), Andrea Herzka (OHSU), Traci Kinden.

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### 1. CALL TO ORDER AND REVIEW OF MINUTES

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Alissa Craft called the meeting of the Health Technology Assessment Subcommittee (HTAS) to order at 1:00 pm. Ahmann, Craft and Mackay were present.

**Action:** The February, 2013 minutes were approved with no changes by a vote of 3-0 (Absent: Keenen, Waldmann).

Craft modified the agenda to accept public comment from Paul Radensky. Radensky introduced himself as a physician by training. He represents McDermot, Will & Emery, which represents Roche Diagnostics Corp., which makes diabetes test supplies.

Radensky said he appreciates the difficulties in developing policies for diabetes. He said that a small percentage of patients can still be thousands or tens of thousands of patients who would fall outside a 95 percent interval. He said that Medicare had started to restrict coverage for test strips to one per day for non-insulin-treated, and three per day for those treated with insulin, but found it was not possible to have rigid fixed policy limits. He expressed concern about the proposed coverage recommendations for patients not being treated with insulin. He said there can be a need for individualized testing when there are changes in diet or medication or when patients have other illnesses. He noted that the report focused on two studies. One showed noninferiority, and was based on less than 200 patients outside the United States. He said that Kaiser has two cohort studies with 24,000 patients and 31,000 patients respectively, which he said support that more frequent testing leads to better outcomes. He also expressed concern about using an HbA1c of 8.0 as a cutoff. He said the data shows no clear inflection point indicating that management should change at this threshold.

Dr. Ralph P. Eccles also testified on the topic of self monitoring of blood glucose. He is a stockholder in the Klamath Falls managed care organization which may become a CCO, but disclosed no other conflicts of interest. He testifies, however as a diabetologist. He said every patient is different but he also believes that the largest single item in the Medicare budget is blood glucose test strips. These are expensive items and he said he wishes there were more competition on price.

He referenced the 2013 ADA recommendations, which lack a recommendation for testing for patients not at risk for hypoglycemia. He said in an elderly patient with renal failure, testing once per week to monitor for renal failure might make sense. But generally speaking he said patients treated with diet, exercise and metformin and not on any special program don't need to test at all. He can also see the need for testing before driving for patients on sulfonureas who have had hypoglycemic episodes. However when he works with residents who have patients on diet, exercise and metformin, he will ask residents why they are recommending testing. Often he recommends nightly testing for six weeks; then sends patient to a diabetes educator to work on dietary changes. He said he doesn't see any benefit from testing one time per week for most patients. He would like providers to be able to get test strips for patients by submitting that the patient is in an education program. In addition, other options are available to reduce utilization other than coverage restrictions. For instance, in his local CCO, patients have to go to the CCO office to get test strips, so the CCO has direct control. By contrast, with Medicare, he has to fill out a three-page form every six months. He requested that the program be managed with a minimum of paperwork.

## 2. REVIEW OF VbBS recommendations

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- A) Shaffer reviewed the process where the VbBS has reviewed the coverage guidances developed by HTAS. In the cases where VbBS made changes, Shaffer explained that HTAS has the option of agreeing or disagreeing with the changes made by VbBS.
- 1) For Vertebroplasty, Kyphoplasty and Sacroplasty, VbBS agreed with the HTAS recommendations, but the condition is below the funding line. As a result, even in nonroutine cases the surgery would not be covered under the Oregon Health Plan unless the comorbidity rule applies.
  - 2) For MRI for breast cancer diagnosis, VbBS suggested no changes in prioritization or coverage, and recommended a diagnostic guideline specifying that MRI for breast cancer is not covered.
  - 3) For diagnosis of sleep apnea in adults, the VbBS recommended a new diagnostic guideline for the Prioritized List.
  - 4) For treatment of sleep apnea in adults, the VbBS recommended changes to the coverage guidance to clarify that both CPAP and an oral appliance must fail or not be tolerated before surgery could be covered, and recommended a revised guideline note defining conditions for coverage.

### **Action:**

The subcommittee voted 4-0 (Absent: Waldmann) in support of the VbBS wording changes for the coverage guidance on the treatment of sleep apnea in adults after minimal discussion.

- 5) For continuous glucose monitoring in diabetes mellitus, Shaffer reviewed the history on the coverage guidance. Based on expert testimony HTAS had recommended coverage for retrospective monitors for those with Type 1 diabetes but not for Type 2 diabetes.

For the real time glucose monitors, the coverage was linked to insulin pump usage/ consideration as well as HbA1c levels greater than 8 or history of hypoglycemia. VbBS wanted both types of monitors linked to the same criteria. Shaffer noted that expert testimony indicated that for the retrospective monitors, the restrictions might not be appropriate, as the benefit from those monitors is for those with controlled diabetes who might be at risk for hypoglycemia, not those with uncontrolled diabetes. Craft reviewed the VbBS wording adjustments, noting that insulin pumps would only be covered for those with Type 1 diabetes, and then only for those meeting the conditions listed. Neither real-time nor retrospective monitors are recommended for coverage in type 2 diabetes patients.

Shaffer raised one additional issue. The draft guidance has ambiguity regarding the relationship of the three coverage conditions for those with Type 1 diabetes. He proposed that the language change to recommend coverage only for type 1 diabetes mellitus patients for whom insulin pump management is being considered, initiated or utilized, and who have HbA1c levels greater than 8.0% or a history of recurrent hypoglycemia. Craft and Ahmann had thought that any of the three conditions would require coverage of a continuous glucose monitor. MacKay said he believes that it should be limited to those on an insulin pump. Craft clarified that MacKay intended to not allow a continuous monitor for patients on a pump but without recurrent hypoglycemia or HbA1c over 8 percent. After discussion the subcommittee decided to add bullets (as shown below) to clarify. The subcommittee agreed that those on an insulin pump not meeting these conditions could monitor with test strips and would not be provided a continuous glucose monitor. MacKay noted that the word “considered” leaves the door open for potential abuse, but after discussion the subcommittee decided not to make any additional changes at this time. Craft clarified that VbBS had also changed the draft to recommend noncoverage for type 2 diabetes patients.

**Action:**

The subcommittee modified the Coverage Guidance box language as shown below for review by the HERC. 5-0

HERC COVERAGE GUIDANCE

Continuous blood glucose monitoring with real-time or retrospective continuous glucose monitoring systems should only be covered for Type 1 diabetes mellitus patients for whom insulin pump management is being considered, initiated, or utilized and who also have one of the following:

- HbA1c levels greater than 8.0%, or
- a history of recurrent hypoglycemia.

Real-time and retrospective continuous glucose monitoring systems should not be covered for Type 2 diabetes mellitus patients.

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### 3. Review of public and expert comments

#### A) Self-monitoring of Blood Glucose.

Alison Little reviewed the expert comment disposition. She noted one correction to the document: the ROSES study was in the Cochrane review, contrary to the expert comment disposition document shown in the meeting materials. Staff will correct the expert comment disposition.

Keenen asked about comment #20, which references the ACCORD trial. He questioned why there would be increased mortality with tighter control. Joarder said this is a controversial area, but experts believe it may be related to hypoglycemic events.

Waldmann asked Joarder for her definition of a significant HbA1c reduction in a type 2 diabetes patient. He is also concerned that the 0.3 percent reduction in HbA1c, which may not be significant, disappears after a year. Joarder said that some believe 0.3 is significant; others say 0.5 is the threshold. Joarder believes 0.3 percent is significant as a UK PDS study showed that a 1 percent decrease in HbA1c is associated with a 37% decrease in risk of microvascular complications. Also, in the Cochrane review, when you see more adherence to treatment you see a greater reduction. Also the FDA literature uses 0.3 and 0.4 as clinically significant for medication. Also, the Clar and Cochrane reviews show a greater reduction in HbA1c with greater adherence to testing. Joarder also said that the population which didn't show a benefit at one year is a very narrow population—HbA1c of 7.3 to 7.4, testing once per week. You can't generalize based on that study. The other study only had 17 subjects. Therefore, she questions the validity of that statement for a broad population.

Since our last meeting, she has spent time reviewing the Clar review. The Clar authors point out that testing can't be separated as an outcome in itself or as a tool for evaluating other intervention. Testing is only meaningful in the proper context. In those studies where there was proper education, there was a trend towards greater significance. Because of the large number of poor studies she believes we do not have evidence that more frequent testing is not effective.

Keenen asked how long it takes A1c to change if you modify treatment. Joarder said she treats it as a valid estimate after three months. Keenen asked whether there are multiple tests for HbA1c? Joarder said there are multiple measures, but they are fairly reliable. Craft asked what the variability is from lab to lab. Joarder said she does not know. She said that some medications can influence accuracy but she doesn't know the exact variability. Craft said that we can't know whether 0.3 percent is within the normal variability of the test.

Little said there is debate about the threshold for clinical significance. Some studies say 0.5 percent. Based on her understanding, the FDA says 0.4 percent is the threshold. She has not heard of a 0.3 percent threshold. Craft said she did an Internet search and found 6 different methods of HbA1c testing with up to a full 2 percent difference in results. This may not be current, however.

Mackay that this is a difficult area to study. During a study, patients may test, and make positive behavior changes. Once the study is complete, they may revert to old behaviors. Waldmann said that the endocrinologist may tend to see a more dedicated patient, which may be because the general practitioner doesn't do enough education. Joarder said that she sees two different populations. In her practice the majority are the worst controlled, not necessarily the most motivated. Many of her patients who are on Medicaid have a lot of comorbid conditions, and many of them are not the most motivated. Her type 1 diabetes patients may be more motivated than those seen in primary care, but that isn't true for the type 2 diabetes patients.

Little reviewed the public comment disposition. She said we received many comments from diabetic educators, who care passionately about what they do and how they manage diabetes. In most cases staff has no response to these as they do not address the evidence.

Waldmann then suggested that the subcommittee review the disposition comments highlighted in red as "for HTAS discussion" from the meeting materials. On comment #5, there was the suggestion to allow test strips for patients on basal insulin because it is not clear whether the studies included this type of patient. Mackay said he would support getting rid of the "multiple daily" language. Ahmann agreed. Waldmann doesn't think it's different than the sulfonurea as either type of patient can have a risk of hypoglycemia. If you cover one, you need to cover the other. He is not sure we need to cover either, but it's the same issue. Craft said there is a greater potential for dosing error with insulin than with pills. She's not sure whether the risk might be interesting. Mackay noted that patients on basal insulin are those who can't get an adequate benefit from pills, so are considered to have complicated diabetes. He said this is another argument to measure glucose for glucose control (as opposed to hypoglycemia). Keenen said he understands the evidence, but has a relative who is caregiver for a person with diabetes taking two insulin injections per day, who finds the test strip results to be a tool in monitoring diet for the person she is caring for. He said that his experience doesn't fit with the evidence.

Craft said care of the individual patient vs the population is a major challenge for the subcommittee. For our purposes we need to base the decision based on a populations. She said that if she were sitting in the audience she might have something different to say than she does when she reviewed the evidence.

Waldmann raised the question, when we have murky evidence, which way do we err? He tends to go on the side of not covering it. It behooves the individual requesting coverage to show evidence that it is helpful. Coffman said that when this goes to VbBS their policy has been to reduce coverage only when they see evidence of no benefit or harm. Shaffer clarified that current coverage is 100/90 days overall, and 100 strips per 30 days for patients on basal or multiple daily insulin injections. Craft asked the subcommittee to make a decision; none was made.

Craft requested three-minute verbal comments from the public. Two individuals testified. Andrew Ahmann is an endocrinologist at OHSU. He declared a conflict of interest in that he did some consulting for Zanofti but not in the area of glucose monitoring. He said that the task is difficult because you are looking for a singular answer but patients vary. A few years ago there was a decision not to monitor glucose in the hospital and now hospitals are reversing their positions. They included a large number of studies which confused the issue, and made a decision based on those studies that didn't get the right message

out based on those studies. The Clar report was mentioned 22 times in the responses to comment. He said that when Clar describes something as a good study it didn't mean it was clinically important but that it was high-quality from a research perspective—studies were described adequately, randomized, blinded, etc. The study quality doesn't say anything about the clinical relevance of the results. The Clar study said the evidence base didn't allow us to answer our original primary or additional questions. The studies did not provide information on patient outcomes by treatment received or by combinations of treatments received. Most studies did not even provide a breakdown of the treatments that patients were taking. Most if not all the randomized controlled trials treated self monitoring of blood glucose as an intervention in and of itself (which it is not). Ahmann concluded by mentioning the St. Carlos study, a newly published study. The study is a rebuttal to the concept that you don't want to get to 6.0% HbA1c. He said that was not what the ACCORD trial said. It's safe to get to six if you don't have hypoglycemia.

Cheryl Moore also testified. She is a nurse and diabetes educator. She is representing herself and the American Association of Diabetes Educators. She also has a son with type 1 diabetes. She discussed this meeting at a recent conference. People were astounded at the suggestions being made to restrict coverage. The use of SMBG as an end in and of itself is not useful. It is a behavior modification tool, providing feedback for people in making choices. To say that if you test one time per week you are going to have any useful info whatsoever is suspect. Basal insulin is adjusted every couple of days based on fasting blood glucose, so with one test per week, you cannot adjust the dose to achieve your goals. She doesn't believe that 8.0 is an appropriate goal. A more appropriate goal is 6.5 or 7.0; otherwise you are doing damage to the intima of the blood vessels. If people test and don't do anything about it of course it will make no difference at all. But if they have education and information from physicians along with testing, then they will be able to change their diet, activity and medications. If we rob them of that we are robbing them of health. People of color and low socioeconomic status are most impacted by this disease. She said they are the people you are taking these strips away from.

Coffman pointed out that coverage for this service is determined by administrative rule. Not something that the commission defined as a part of the prioritized list. Those detailed decisions are made by DMAP, not VbBS.

Craft referred committee to page 27, which contains the box language. The changes shown in blue could be added or struck out. Shaffer clarified that he listed them for consideration based on public and expert comments, but also said there may be implementation difficulties with many of them.

Waldmann said that the blue language does address objections. MacKay said that the words, "comorbid" and "elderly" are vague and need to be defined. Waldmann would limit the exception for those on corticosteroid therapy to those on systemic corticosteroid therapy. Craft clarified that we could take out the changes shown in blue, which would be consistent with what we sent out for public comment, leaving the details to administrative rule. Waldmann asked what would be the advantage with leaving these out if the consensus is that they are reasonable additions.

Waldmann moved to accept with wording changes as specified above. After discussion, the group agreed to remove the exception for elderly patients (as they would likely have

comorbid conditions), add the words “systemic” to the exception for corticosteroids and to clarify that the exception for comorbidity is for those with “comorbid conditions complicating diabetic control.”

**Action:** Refer the draft coverage guidance as modified to VbBS and HERC. **Motion approved 5-0.**

### HERC COVERAGE GUIDANCE

For patients with Type 2 diabetes mellitus not requiring insulin, home blood glucose monitors and related diabetic supplies are recommended for coverage only for those who have initial HbA1c levels greater than 8.0%, and in sufficient quantity to allow once a week testing. Such coverage should include a structured education and feedback program for self-monitoring of blood glucose (*strong recommendation*).

Additional supplies for self-monitoring of blood glucose, up to 100 test strips for 90 days, are recommended for coverage for the following patients with Type 2 diabetes (*weak recommendation*):

- Patients newly diagnosed and receiving diabetes education
- Patients changing treatment regimens
- Patients with unexplained or new onset hyperglycemia
- Patients with recent history of hypoglycemia
- Patients with comorbid conditions affecting diabetic control
- Patients with microvascular or macrovascular complications of diabetes
- Patients on basal (once daily) insulin
- Patients on systemic corticosteroid therapy

For patients with insulin-requiring diabetes mellitus, including those with Type 2 diabetes using multiple daily insulin injections, home blood glucose monitors and related diabetic supplies are recommended for coverage and should include a structured education and feedback program for self-monitoring of blood glucose (*strong recommendation*).

*Note: This guidance does not apply to pregnant women.*

## **B) Carotid Endarterectomy**

Craft asked Landry for feedback on the revised coverage guidance. Landry discussed the gap in recommendations for the group with 50-70% stenosis. He believes that it would be appropriate. For that group you have to distinguish between symptomatic and asymptomatic. For the 70-99% stenosis groups, both symptomatic and asymptomatic patients will benefit. For those with 50-70% stenosis, coverage is recommended for symptomatic patients only. But it should not be a strong recommendation and should be limited to those who have failed medical management.

Craft said we could add the language from the handout with a weak recommendation. Shaffer noted the algorithm would result in a strong recommendation, but can go to weak

based on committee's recommendation. Landry does not believe the difference is overwhelmingly significant in a clinical sense. Waldmann moved to accept the recommendation on the 50-70% symptomatic group. The motion was approved 4-0 with Mackay abstaining, as he had to step out of the room for part of the discussion.

Craft then reviewed the new language regarding screening added to the box, and asked Shaffer for background. Shaffer said this is an attempt to define a category for which screening would be appropriate. The recommendation is based on professional society guidelines (not the evidence review, which doesn't speak to this question). Shaffer said this is a restrictive interpretation of the recommendations from the professional societies. Landry agreed that this is reasonable. He said the issue of carotid screening is not resolved yet. There are individual institutional studies and consensus recommendations but nothing really definitive.

Waldmann said he wonders if the criteria would also be applicable to younger people. Craft asked for a motion about whether to add these criteria for screening. Ahmann said he is against recommending this paragraph on screening criteria based on the consensus recommendation and made a motion accordingly. The motion carried 5-0.

After the vote, Shaffer drew the subcommittee's attention to the evidence summary and appendix in the draft coverage guidance, regarding the conversion from Doppler ultrasound measurements to percent stenosis. There was no discussion.

No changes to Grade or algorithms were requested, but staff will update the full document to make it consistent with the updated box language. Craft asked that he do so.

Shaffer also noted there is a group we are not addressing--coverage for asymptomatic patients with 50-70 stenosis. Craft noted that in the absence of screening, these patients would only be identified due to incidental findings, so plans could deal with them as exceptions. She said there would be no evidence. The group agreed to stay silent on coverage for these patients.

#### HERC COVERAGE GUIDANCE

Carotid endarterectomy is recommended for coverage in patients with 70-99% carotid stenosis without near-occlusion (*strong recommendation*).

Carotid endarterectomy is not recommended for coverage for patients with less than 50% carotid stenosis (*strong recommendation*).

Coverage of screening for asymptomatic carotid artery stenosis in the general primary care population is not recommended (*strong recommendation*).

For patients with 50 – 69% carotid stenosis who are symptomatic (recent transient ischemic attack or ischemic stroke), carotid endarterectomy is recommended for coverage only for those who have failed optimal medical management (*weak recommendation*).

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#### **4. Review of Draft Coverage Guidances**

##### **A) Femoroacetabular Impingement Syndrome**

Craft invited public comment from Tracy Kinden, a FAI patient of Dr. Herzka. Kinden testified regarding the pain and disability she faced before her surgery. She had pain with exercise

including hiking and everyday activities. She said her life had become focused around pain management. She didn't like the option of bilateral hip replacement because it would likely have to be done multiple times because of her age. Her comments had to be cut short because of time, but Coffman invited her to submit written comment when the time comes.

Coffman reviewed history of the topic to date. The topic was reviewed by EbGS in 2012, working from evidence from the Washington Health Technology Assessment and NICE. The group started with recommendation of noncoverage, then went to statement that they couldn't make a recommendation based on the available evidence. The HERC approved the guidance, but later requested a full review after feedback from medical directors. This revision started the Commission towards the path of adding the modified GRADE methodology.

Herzka said that Livingston was interested in creating guidelines for medical necessity. Is that not desired? She was surprised to see the strong recommendation not to cover it. Coffman said this was a starting point based on where the conversation left off during the EbGS review. Shaffer agreed. This evidence summary is the same as was used by the EbGS with the expectation that it may evolve. Herzka offered assistance in developing criteria for coverage if appropriate.

Gingerich suggested that based on staff discussion earlier in the day it might be helpful for Herzka to define what she is looking for, given the limited time remaining in the meeting. Herzka said commercial insurers generally do a pretty good job in defining medical necessity criteria. It is usually a younger individual, aged 14-55, with hip pain but no arthritis, who are disabled or who have significant symptoms, along with radiologic evidence of FAI and who have MRI or other imaging showing chondrolabial injury. All these things come together to create a picture of symptomatic FAI. She said that xray showing FAI morphology isn't sufficient without the other criteria. Of people of European descent, 20 percent have the morphology.

She said there are also some patients who have one piece that is different (e.g., butt pain, not groin). In those cases she would do a diagnostic anesthetic injection to confirm the diagnosis, and to rule out other conditions such as piriformis syndrome. Keenen asked whether this is a routine part of diagnosing the condition. Herzka said that the injections are not routine. Waldman said a joint injection would also relieve arthritis pain. Herzka agreed but said that the injection would indicate FAI only if everything else seemed to align, including when the pain occurs and how they recreate the pain on exam. None of the criteria for case definition is specific, it is a combination of factors which lead to the diagnosis. Waldmann said that it not an easy diagnosis to make. He asked her how many orthopedic surgeons could make this diagnosis correctly. Herzka said the majority of the diagnoses she gets from other orthopedic surgeons are correct diagnoses, but she does get incorrect diagnoses from primary care providers, physical therapists and chiropractors.

Waldmann asked about the difficulty of the procedure. Herzka said it does require special training and interest in hip arthroscopy.

Shaffer said the case description sounds sensible, but he asked whether it could be used for study purposes. Have there been studies with a better case definition? Herzka said that most of the case reports or case series and cohort studies are looking at symptomatic patients, usually with groin pain, FAI morphology and associated chondrolabral tear on MRI.

Some may also include traumatic labral tears or labral tears in the absence of FAI. The actual number of labral tears that occur in the absence of FAI is very small.

Keenen asked Herzka to define FAI morphology. She said there are two types, cam and pincer, more common in men and women respectively, and described the measurements needed to confirm it and the potential for causing symptoms and injury. Keenen asked about what kind of imaging is used. Herzka said she uses specific kinds of x-rays which allow her to rule out arthritis, as arthritis patients don't have good outcomes with this surgery. Keenen asked how much is the diagnosis based on history and physical versus interpretation of diagnostic studies. Herzka said it is about 60 percent history and physical. Imaging has good negative predictive value but is overly sensitive.

Keenen said there is a study with 250 patients with an improved Harris hip outcome score, and asked what is the success rate using that measure? Herzka said the success rate is between 60 and 95 percent. Keenen asked if that improvement was based on the Harris score. Herzka said no, that score is not used any longer. While surgeons began doing FAI in 2004, the surgery was really modernized in about 2007. Before 2007 they only had arthritis scores to measure with, but there is a ceiling effect with Harris hip scores, as they are designed for older patients with arthritis. Other newer instruments are more appropriate for this population. There are two new scales that are used and are validated for the young FAI populations. These tools have only been available for about nine months, and used in studies for about six months. Data should improve as time goes on. Based on the newer criteria, study success rate varies according to the population studied. She cited a study which she said had the broadest mix of patients.

Waldmann asked whether the wide range of success rates is dependent on the operator or something else. Herzka said that the rate is dependent on the population. Keenen said there are relatively few orthopedists who would be willing to do this surgery. Waldmann requested additional information about the topic for the next meeting.

The subcommittee will revisit the topic June 24. Dr. Shaffer said that he would work with Herzka to develop coverage criteria so that the subcommittee has something to look at if it does decide to cover the service.

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## 5. New Topics

Shaffer asked the subcommittee about two potential new topics.

One is whether DEXA screening for osteoporosis should be done under the age of 65 or more frequently than every two years. The group agreed that it was a good topic and that outside expertise is needed. Coffman asked Keenen whether he could serve as the expert. Keenen said he would need an endocrinologist working on osteoporosis, or a radiologist. He would prefer an endocrinologist. He recommended a candidate.

The second topic is newer radiation therapies—stereotactic body radiation for non intracranial lesions or intensity modified radiation therapies. There is a Washington HTA which would serve as a core source. The group agreed it was an appropriate topic and that expert input is required.

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## **6. Adjournment**

The meeting was adjourned at 4:20 pm. The next meeting is scheduled for June 24, 2013 from 1:00-4:00pm in Room 117B of the Meridian Park Hospital Community Health Education Center in Tualatin.