CANS newsletter

Attention Neurosurgeons-Message from the President

Praveen Mummaneni, MD, President

The California Association of Neurological Surgeons Annual Meeting is scheduled for January 13th-15th, 2017 at the Intercontinental Mark Hopkins in San Francisco, CA! Our President, Dr. Praveen Mummaneni from UCSF, has put together an engaging program!

PLEASE SAVE THE DATE!

We have secured a fabulous rate of $219 for the hotel and you can start booking now! Visit www.cans1.org and click on the CANS annual meeting bullet in the calendar!

Draft Agenda is below:

The Evolution of California Neurosurgery Training and Practice

SCHEDULE of EVENTS January 13-15, 2017

FRIDAY

1-4pm CANS Board Meeting (open to all members-buffet lunch before)

6:30 – 8:30 Opening Night Reception

SATURDAY

6:30–7:30 Continental Breakfast- Please visit EXHIBITS

7:30-7:35 Praveen Mummaneni, M.D. **President's Report**

7:35-7:40 Mark Linskey, M.D. **Secretary's Report**
Voting: BOD/Nominating Committee

7:40-7:45 Marshall Rosario, M.D. **Treasurer's Report**

Session 1: How far can we stretch ourselves?

8:00-8:30 Dr. Michael Lawton: Overlapping intracranial surgery, safety & efficacy

8:30-9:00 Dr. Michael Wang: Overlapping spinal surgery, how to work in urgent cases

9:00-9:30 Dr. Bill Caton: How to cover multiple hospitals/ER on call

9:30-10:00 Dr. Alan Scarrow - A medical-legal perspective on overlapping surgery

10:00-10:20 Q&A, Panel Discussion

10:20-10:50 Break - Please visit exhibits

Session 2: Finding My First Job in Neurosurgery

10:50-11:10 Deborah Henry: career choices in neurosurgery

11:10-12:00 Panel Discussion - What I Wish I Knew When I Looked for My First Job
Drs., Marc Vanefsky, Ken Blumenfeld, Moustapha Abou-Samra, Langston Holly, Javed Siddiqi, Michael Virk, Omid Hariri, Doris Wang

INSIDE THIS ISSUE:

ATTN Neurosurgeons-President's Message- *pages 1- 2*
Exhibitors!! – *page 3*
Doc Wellness – *page 4*
Brain Waves – *page 5*
Transitions in Neurosurgery – *pages 6-7*
Longtime CANS member – *page 7*
Q &A on new law– *pages 7- 8*
ACS Launches online – *page 8*
UnitedHealth gets into bed – *pages 9-10*
Feds allow some.. -*pages 10-11*
Observation of the Month – *page 11*
EXHIBITORS- *page 11*
Calendar – *page 12*
CANS Director – *page 13*

12:15 – 1:30 Lunch with Exhibitors at the TOP of the MARK

Session 3: Neurosurgery on the hot seat

1:30-1:50 Dr. Shelly Timmons, Washington CMTE Update
1:50-2:10 Dr. Jack Knightly: Building quality into a neurosurgery practice
2:10-2:30 Katie Orrico, New Regulations and Planning for the Future
2:30-2:50 Dr. Richard Pan (California Legislator): Update on medical practice in California, Legislator's Perspective
2:50-3:10 Dr, Dev Gnanadev- Medical ethics-How NOT to lose your California medical license
3:10-3:30 Dr. Ann Stroink- CSNS update
3:30-3:45 Q/A
3:45-4:15 Panel discussion
4:15-4:30 Praveen Mummaneni, M.D. Closing Remarks

SATURDAY BANQUET *- Must purchase ticket*

6:30-7:00 PM Award Presentation: Dr. Mitchel Berger: Pevehouse Award Winner

SUNDAY

7:00-7:40 Breakfast/Please visit Exhibits

Session 1 The future of neurosurgical training in California: sponsored by the NREF

8:00-8:20 Dr. Nicholas Barbaro – Updates from the RRC on residency training
8:20-8:40 Dr. Rick Boop – CAST Updates on fellowship training certification
8:40-9:00 Dr. Marvin Bergsneider – CV misrepresentation among neurosurgery resident applicants
9:00-9:30 Panel Discussion: Dr. Michael McDermott, Dr. Gary Steinberg
Dr. Frank Hsu, Dr. Alex Zouros, Dr. Bob Carter, Dr. Javed Siddiqi

Session 2: Keynote Lecture

9:30-10:15 Strategic Planning for Healthcare Reform: Dr. Robert Harbaugh

10:15 BREAK-PLEASE VISIT EXHIBITS

10:30-12:00

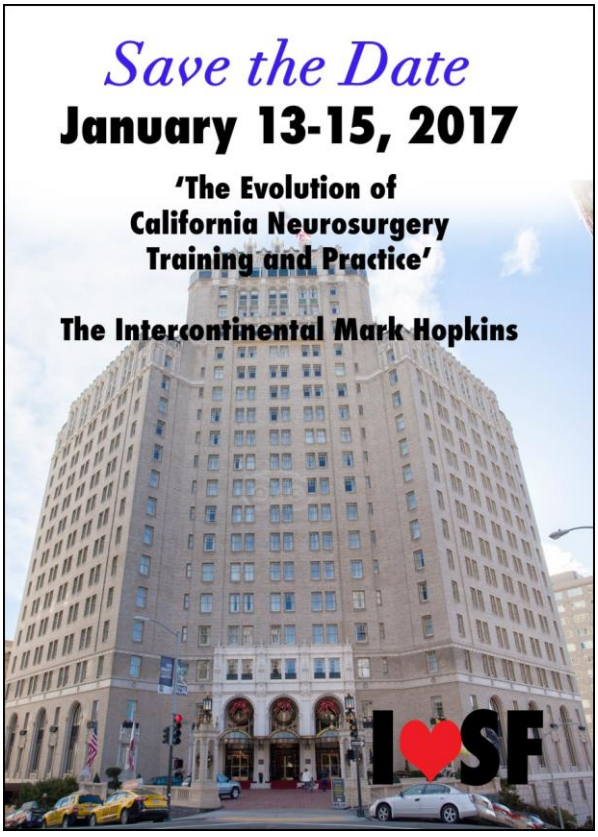
Resident/Fellow Presentations Socioeconomic or quality improvement program

Loma Linda Regional Medical Center
University of California, San Diego
University of California, San Francisco
Cedars-Sinai Medical Center: Lindsay Ross
Riverside University Health System
University of Southern California
University of California, Los Angeles
Stanford University
Dr. Tamar R. Binyamin, University of California, Davis
'Restrospective review comparing the Vasospasm rates & outcomes of blister type & saccular intracranial aneurysms.'
Dr. John Roufail University of California, Irvine
Desert Regional Medical Center

12:00 Award for Resident Presentation

Sincerely,

Praveen V. Mummaneni MD
Joan O'Reilly Endowed Professor
Vice Chairman
UCSF Neurosurgery
CANS President



EXHIBITORS: CONTACT Emily for more information!
emily@cans1.org or 916.457.2267 or click here!

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Doc Wellness Program Re-emerges

Randall W. Smith, MD, Editor

Years ago, the Medical Board of California had a physician wellness program to assist docs in dealing with substance abuse. The MBC killed the program because it felt such a program did not adequately fit with the MBC reason for existence which was to protect the public. It couldn't be bothered with actually helping the people who pay for its existence.

Lo and behold, the nearsightedness of this decision has come home to roost as the MBC, as a common part of disciplining docs with substance abuse, found it had to spell out details of dealing with the abusing doc when it put them on probation, most often indicating the doc needed to find an outfit that would do the monitoring of the doc, testing for compliance, etc. Since the MBC was so involved, SB1177 was passed by the legislature and signed by the Governor which proposes to internalize the doc substance abuse issue.

This bill would authorize the board to establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with a private 3rd-party independent administering entity meeting certain requirements. The bill would require program participants to enter into an individual agreement with the program that includes, among other things, a requirement to pay expenses related to treatment, monitoring, and laboratory tests, as provided.

It is noted that nothing in the bill defines substance abuse but one must presume the MBC would flesh that out along with other obviously needed details. It is further noted that the legislation "authorizes" but apparently doesn't mandate the MBC to act and also includes the verbiage "If the board establishes a program . . ."

Nonetheless, let's hope this is an idea whose time has re-come. ❖

CANS MISSION STATEMENT

'To Advocate for the Practice of California Neurosurgery Benefitting our Patients and Profession'

Brain Waves

Deborah C. Henry, MD, Associate Editor

My son and I visited Japan for two weeks this summer. Initially I had no interest in going. It was his choice. After 48 hours there, I loved the place! The Japanese culture promotes cleanliness, respect, and service. Excellent service is expected. Because of this, there is no tipping. How refreshing it was to never have to worry about do I have to tip and how much. Tipping has become so invasive in our society. Tip jars are multiplying in establishments where we never tipped before. In California, as far as I know, there is no reduction in salary as it is in some states for positions that have customarily received a tip as tips is a necessity for those workers to make a living wage.

As much of medicine has moved into the customer service areas on health and beauty, is tipping required here? Sometime ago I utilized a medical masseuse. I have bad shoulder and neck issues and the deep tissues massages were covered by my health insurance at the time. A regular masseuse in a spa is tipped. Do I tip a medical masseuse? In the end, I did, mostly because I knew how little the insurance was going to pay. Dermatology offices employ individuals to do photofacials, laser treatments, and sometimes Botox work. In a spa, anyone giving a facial, gets a tip. Do individuals working in a medical spa receive a tip? Should they?

I suspect the neurosurgical office personnel are a long way off from receiving a tip, but maybe not. Perhaps the concierge fee is a way of tipping to insure prompt service. So I googled neurosurgery and concierge to see what is happening. Most of the concierge programs related to neurosurgery appear to be assistance in travel and hotel arrangements (John Hopkins, a team in Dallas and more) or assistance with dealing with cancer (a program in Colorado) though a team in Los Angeles may be starting a true concierge service. Perhaps the acronym *tips* does not really mean "to insure prompt service" but "to insure paying someone" for the services done. I hope Japan doesn't change. It was nice for two weeks not to have the stress of tipping. ❖

DO YOU KNOW A NEUROSURGEON NEW TO CALIFORNIA?

TELL THEM ABOUT CANS AND DIRECT THEM TO THE CANS WEBSITE: WWW.CANS1.ORG! THERE IS A MEMBERSHIP APPLICATION ON THE SITE!

Transitions in Neurosurgery

John T. Bonner, MD, Associate Editor

An October 13, 2016 press release from the National Institutes of Health announced a third round of grants to support the NIH's Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative. Thus, NIH's total fiscal year investment in BRAIN is over $150 million. The press release noted that "over one hundred new awards totaling more than $70 million will go to over 170 investigators working at 60 institutions." Commenting on these awards, Joshua Gordon, M.D., Ph.D., director of NIH's National Institute of Mental Health, reported that "This year, more projects are based, at least in part, on data from humans. Some of these projects are aimed at fine-tuning brain stimulation and other promising technologies for the treatment of mental illnesses."

In 2013, the National Institutes of Health started the "Brain Initiative." This initiative was established to "accelerate the development and applications of new technologies to examine the dynamic practices of the brain." It encourages study into how "individual brain cells and complex neural circuits interact at the speed of thought." This initiative also promotes research into "how the brain encodes, stores and retrieves vast quantities of information." It wants to investigate links between brain function and behavior. The NIH noted that 100 million Americans suffer from devastating brain disorders at some point in their lives. Although this number seems exaggerated to me, it could be a result of the link between brain physiology and psychiatric dysfunction.

We, as neurosurgeons, appreciate the fact that the brain is the most complex organ in the body, so this Initiative presents many avenues to study new frontiers in brain function and dysfunction. As NIH Director Francis Collins noted: "How the brain works and gives rise to mental and intellectual lives will be the most exciting and challenging area of science in the 21st Century."

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A recent opinion piece in the *Wall Street Journal* addresses the deterioration of the physician-patient relationship due to automation and EHR mandates (Caleb Gardner, M.D. and John Levinson, M.D., "Turn Off the Computer and Listen to the Patient", *Wall Street Journal*, September 22, 2016, p. A19). Dr. Caleb Gardner, a resident in Massachusetts and Dr. John Levinson, a cardiologist from Massachusetts General Hospital and Harvard Medical School, reported that medical students and residents are spending more time with computer screens than with patients, and blame the Electronic Health Record (EHR) mandate as a major cause of the disconnect. Drs. Gardner and Levinson noted that primary care appointments with patients are now as short as five minutes, with the physician spending much of the time typing instead of attending to the patient and performing a physical examination. Commenting on this problem, Drs. Gardner and Levinson noted that "the practice of medicine is a subtle art. Doctors need to give patients their undivided attention." They found that computer systems are "distracting and burdensome." Further, senior physicians are retiring early because of the EHR mandate, and young doctors find "the humanity draining from the profession to which many were

drawn because of a desire to interact and connect with people." Economic forces, such as the EHR mandate, have decimated private medical practices and the profession becomes more and more corporatized. Many physicians now work as employees of hospitals and larger hospital systems, resulting in fewer physicians in private practice.

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As an interesting aside, the Associated Press published a letter Albert Einstein wrote to his son, in which Einstein shares the news that he had solved the Unified Field Theory. Einstein erred in this conclusion as the problem remains unsolved today. Nonetheless, Einstein's letter provides rare insight into his life's work and offers a glimpse into his relationship with his son. Einstein's one page hand written letter is expected to fetch over $100,000 at auction.

Tidbits from the Editor

Longtime CANS member receives CMA Award; CANS PE elected to BOT

Philipp Lippe, M.D., a CANS founding member, President in 1978 and Byron Cone Pevehouse Distinguished Service Award recipient in 1997, was given the Specialty Delegation/California Medical Association **Lifetime Award** at the recent CMA House of Delegates meeting. The award bore the inscription:

Presented to Philipp Lippe, MD
For your many years of selfless dedication to Medicine, Neurosurgery, Pain Medicine, Industrial Medicine, The Specialty Delegation and The California Medical Association. October 2016

The award could just as easily have stated:
And for your many years of selfless dedication to the California Association of Neurological Surgeons.

At the same meeting, CANS President-elect **Ken Blumenfeld** was elected as a trustee to serve on the CMA Board of Trustees, only the third neurosurgeon to ever sit on that Board (the other two were Cone Pevehouse and Phil Lippe).

Both Lippe and Blumenfeld are what this writer sees as rarities among CANS leadership: Persons willing to consistently and continuously do the voluntary jobs that require a lot of time and are necessary for the well being of docs everywhere, CA docs especially and CA neurosurgeons most specifically.

Q & A on new law AB 72 prohibiting "Surprise Billing"

AB 72 is aimed at ensuring that patients who schedule care at an in-network facility and unknowingly receive care from a physician who does not contract with their plan or insurer are not subject to bills for out-of-network care they thought would be covered. However, patients whose health plans or insurers

offer an "out-of-network" benefit (which generally requires them to pay higher cost sharing) may utilize that benefit by consenting in writing to do so.

Q: Will I receive payment directly from the health plan or insurer under AB 72?
A: Yes. Health plans and insurers are required to authorize and permit assignment of a patient's right to any reimbursement for services covered under a plan contract to a noncontracting physician who provides non-emergency treatment to a patient at an in-network facility. Even if a patient has not assigned his or her benefits to the noncontracting physician, payment for covered services will be made directly to the physician.

Q: How will I be reimbursed for services by a health plan or insurer under AB 72?
A: Health plans and insurers must pay physicians an interim payment that is the greater of the average contracted rate (including only commercial contracts) or 125 percent of the amount that Medicare reimburses on a fee-for-service basis for the same or similar services in the geographic region in which the serviced were rendered. Geographic regions for AB 72 purposes will be the same regions specified for physician reimbursement in Medicare fee-for-service by the United States Department of Health and Human Services.

Q: When does AB 72 take effect?
A: AB 72 applies to services provided on or after July 1, 2017.

Q: Does AB 72 apply to care furnished in all settings?
A: No. AB 72 applies only if care is furnished in a contracting health facility. For purposes of AB 72 a "contracting health facility" means a health facility that is contracted with the patient's health plan or insurer to provide services under the patient's policy. This includes a licensed hospital, laboratory, radiology or imaging center, and an ambulatory surgery or other outpatient setting.

Q: Does AB 72 apply to patients regardless of their insurance type?
A: No. AB 72 amends the California Health & Safety Code and the California Insurance Code and thus applies only when the patient has an individual or group insurance product that is regulated by Department of Managed Health Care (DMHC) or the Department of Insurance (DOI). It does not apply to services provided to patients enrolled in Medicare, Medi-Cal, out-of-state plans, self-insured employer plans or other products regulated by federal law.

ACS Launches Online Tool to Navigate New Medicare Payment Program

On January 1, 2017, the Centers for Medicare & Medicaid Services will begin the process of changing how physicians are paid for the health care services they provide to beneficiaries. The American College of Surgeons (ACS) has created an online resource center to help surgeons prepare for and navigate the new system—the Quality Payment Program (QPP). The College's QPP resource center can be found at www.facs.org/qpp. Here you will find continually updated informational materials, including a series of videos that walk you through the various components of the QPP.

UnitedHealth gets into bed with the University of California after kicking Covered California in the behind

Chad Terhune of Kaiser Health News penned the following on September 29, 2016 based upon a United Healthcare news release:

The nation's largest health insurer and the University of California Health system are joining forces to create a new health plan option for employers and expand research into patient data.

Under the 10-year partnership, UnitedHealth Group Inc. and the UC system will form an accountable care organization that will be offered to large, self-funded employers statewide. In accountable care organizations, or ACOs, physicians, hospitals and an insurer work together to coordinate care, control spending and share savings.

The for-profit insurer will also open a research lab in the San Francisco area early next year offering researchers at the state-run health system access to a huge national database of patient records.

The collaboration comes as hospital systems and insurers are under increasing pressure from employers, government health programs and their competitors to forge new alliances aimed at improving care and cutting costs. It also reflects the growing importance of data mining to achieve those goals by identifying disease earlier and finding more effective treatments.

The deal marks UnitedHealth's continued interest in growing its California business **despite its decision in May to leave the state's health insurance exchange.**

(United Healthcare's Optum unit was recently awarded a five-year contract to manage pharmacy benefits for the California Public Employees' Retirement System, and UnitedHealth is expanding its presence in Medi-Cal, the state's Medicaid program. The company said it now serves more than 3.5 million Californians.)

The UC system runs five academic medical centers in Los Angeles, San Francisco, San Diego, Irvine and Davis, including hospitals, medical groups, clinics and other outpatient facilities. They will continue to work with other insurers such as Anthem Inc. and Blue Shield of California as network providers and in other ACOs.

But UnitedHealth offered several advantages compared to its rivals in terms of data-mining capabilities and administrative support for hospitals and physician offices through its consulting unit, said David Kraus, chief contracting and clinical strategy officer for the UC Health system.

Kraus said the university system and UnitedHealth want to learn from the mistakes of earlier ACOs and offer employers a more centralized approach that can tap into real-time data as patients move through the health care system.

"A lot of employers have a physical health product unrelated to a mental health product unrelated to their wellness program, which is completely unrelated to the pharmacy benefit. We think it needs to be all together, and we get to build this ACO from the ground up," Kraus said.

UnitedHealth is playing catch-up in a crowded market. Anthem, the nation's second-largest health insurer, has been the dominant player in California for self-funded employers. In that scenario, large employers have the financial resources to pay their own medical claims. They hire an insurer to administer the health plan and create a provider network.

Anthem had a 37 percent share of the 6.4 million Californians covered by the self-funded market in 2014, according to data from the California Health Care Foundation. Cigna Corp. was second with 24 percent market share, followed by UnitedHealth and Blue Shield of California at 13 percent apiece.

HMO giant Kaiser Permanente has a smaller presence in the state's self-funded market. In the fully insured market for large employers, Kaiser Permanente leads the state with a nearly 50 percent share.

The two organizations also want to use the California office of Optum to lure young data scientists into the medical field rather than lose them to game developers or social media in Silicon Valley.

"Everybody is struggling with the fact that Facebook, Google and other tech companies are very attractive and obvious targets for new graduates coming out," Dr. Paul Bleicher, chief executive officer of Optum said. "This will help bring in UC students to work on our data."

Feds allow some to skip the MACRA rules

What follows is a quick glance at next year's biggest reporting changes based on the recent Feds MACRA Final Rule release. Of particular note to neurosurgeons not in big single specialty or multispecialty groups or in Kaiser or Academic medical groups or owned by a hospital, is the exemption from reporting due to low Medicare volume. The Low-Volume Threshold allows qualifying docs to not have to do the MIPS. Of course no MIPS, no bonus but also no negative adjustment of your Medicare billing.

The Low-Volume Threshold is less than $30,000 in Medicare billings **OR** fewer than 100 Medicare patients seen in a year. One might imagine that the solo neurosurgeon or neurosurgeons who practice together but maintain separate billing numbers would likely see fewer than 100 Medicare patients a year. Simply look at your Medicare billings for all of 2016 and if there are 100 or fewer unique Medicare patients, you can skip all the MACRA stuff. Tempting.

A look at the final rules:

1. Low-Volume Threshold Raised: You're only required to bill under MIPS if you bill at least $30,000 in Medicare Part B services OR see more than 100 Medicare patients per year. Approximately two-thirds of Medicare Part B providers will be required to report based on these criteria.
2. Cost Reporting: Although previous versions of the rule had cost measures as a key portion of your total MIPS score, CMS has changed this in the Final Rule. Although you will still report your cost metrics, they will not count in your first year of reporting (2017), and its "weight" has been transferred over to the Quality category of your composite score.
3. Clinical Practice Improvement Activities (CPIA) Requirements Lowered: You'll need to report four activities out of the 93 that are available for at least 90 days to avoid being hit with a penalty. However, if you are recognized as a medical home, you won't have to report any.
4. Expansion of Advanced APMs: Previously experts anticipated that just about all providers would report their QPP data under With the expansion of more organizations into Advanced APMs, and the changes in the eligibility criteria, however, CMS estimates that between 70,000 and 120,000 (5%-8%) providers that bill Medicare Part B will actually qualify to participate in an Advanced APM in 2017. This is an important change because reporting data via an Advanced APM offers an automatic 5% incentive payment on all Medicare payments.
5. Advanced Care Information (ACI) Reporting Minimum Cut: ACI takes over the Meaningful Use program and measures how you use your electronic health records (EHRs). The good news is that MACRA's Final Rule reduced the reporting criteria from 11 items to just five. However, you will need to report them all for at least 90 days to get a 100% score in this category.

6. First Year Reporting Volume Modified: The recent Final Rule changed what you are actually required to report to comply during 2017, and the penalties/incentives that accompany each:
a. Non-reporting: If you qualify to participate in MACRA and don't report, you will be hit with a 4% negative adjustment on your Medicare reimbursements. Currently, qualified providers are in all specialties and practices sizes and include: Physicians, PAs, NPs, CNSs, and CRNAs.
b. Submitting Sample Data: If you just put your toe in the MACRA water and only submit a small portion of what is required, you'll actually avoid a penalty (but won't quality for an increase). If you take it a little bit further and report a part of the year, you'll receive a neutral or small increase to your payments.
c. Exceptional Performance Adjustment: If you dive in head first and report your QPP data for the full year, you'll be eligible for a "moderate" pay increase. And as an added bonus, if you get a final score of 70 or higher, you could also receive the exceptional performance adjustment funded by $500 million set aside by Congress.

The new CMS rule states, "Protection of small, independent practices is an important thematic objective for this final rule with comment. For 2017, many small practices will be excluded from new requirements due to the low-volume threshold, which has been set at less than or equal to $30,000 in Medicare Part B allowed charges or less than or equal to 100 Medicare patients, representing 32.5 percent of pre-exclusion Medicare clinicians but only 5 percent of Medicare Part B spending." ❖

Observation on Aging:

Did you ever notice: The Roman Numerals for forty (40) are XL.

It's that time of year again! Drs., Please talk to your local reps about Exhibiting at the CANS Annual Meeting! Refer them to me: emily@cans1.org or 916.457.2267

Meetings of Interest for the next 12 months:

California Neurology Society: Annual Meeting, November 11-13, 2016, Santa Barbara, CA
Cervical Spine Research Society: Annual Meeting, Dec 1-3, 2016, Toronto, Ontario, Canada
AANS/CNS Joint Pediatric NS Section: December 5-8, 2016, Orlando, Florida.

CANS, Annual Meeting, January 13-15, 2017; Mark Hopkins Hotel, San Francisco, CA

CNS Spine Complication Course, January 26-29, 2017, Park City, UT
North American Neuromodulation Society: Ann. Meet., January 19-22, 2017, Las Vegas, NV
AANS/CNS Joint Cerebrovascular Section: Ann. Meet., February 20-21, 2017, Houston, TX
Southern Neurosurgical Society: Annual Meeting, February 22-25, 2017, Orlando, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 8-11, 2017, Las Vegas, NV
Neurosurgical Society of America: Annual Meeting, April 2-5, 2017, Jacksonville, FL
CSNS Meeting, April 21-22, 2017, Los Angeles, CA
AANS: Annual Meeting, April 22-26, 2017, Los Angeles, CA
AANS/CNS Joint Pain Section Bi-Annual Meeting, May 19-20, 2017 Chicago, IL.
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2017, TBA
New England Neurosurgical Society: Annual Meeting, June 22-24,2017, Chatham, MA
Western Neurosurgical Society: Annual Meeting, September 8-11, 2017, Banff, Alberta, Canada
CSNS Meeting, October 6-7, 2017, Boston, MA
Congress of Neurological Surgeons: Annual Meeting, October 7-11, 2017, Boston, MA
North American Spine Society: Annual Meeting, October 25-28, 2017, Orlando, FL

Any **CANS** member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a two month posting in this newsletter. Submit your text to the CANS office by E-mail (emily@cans1.org) or fax (916-457-8202)—Ed. ❖

The assistance of Emily Schile and Dr. Praveen Mummaneni in the preparation of this newsletter is acknowledged and appreciated.

- To place a newsletter ad, contact the executive office for complete price list and details.
- Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office emily@cans1.org.
- Past newsletter issues are available on the CANS website at www.cans1.org.
- If you do not wish to receive this newsletter in the future, please E-mail, phone or fax Emily Schile (emily@cans1.org, 916-457-2267 t, 916-457-8202 f) with the word "unsubscribe" in the subject line.

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