CANS newsletter

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REMINDER:

***Ken Blumenfeld**,MD, FAANS past President of CANS, is running for the CMA Presidency. You can help him by contacting your local medical society's CMA delegates and asking for their support for our colleague.*

"As your incoming President-Elect I will ensure the independent practice of medicine remains the sole purview of physicians, mentor future physician advocates, and support the diversity of our physician community. Our CMA is the premier medical organization in California. Representation, education, and advocacy is what CMA must do and is what I am about. Let me represent you as the next President-Elect of our great CMA'!

Conglomerate Care

Randall W. Smith, MD, Editor

An article in *California Healthcare* by Chad Terhune addresses the issue of the corporate practice of medicine and how that is flourishing in California as hospitals and other entities easily evade the corporate practice of medicine ban. Here is an edited version.

Hospitals have gobbled up nearly 40 percent of physician practices in California whereas just a quarter of practices were owned by hospitals eight years ago, according to a study published in the journal *Health Affairs*. The study showed that the rapid industry consolidation was associated with higher prices for

INSIDE THIS ISSUE:

primary care visits and treatment from specialists, higher bills for patients and a 12 percent increase in premiums on California's health insurance exchange.

Acquisitions of physician practices by hospitals tend to be small and typically fly under the radar, said Richard Scheffler, the study's lead author and professor of health economics and public policy at the University of California-Berkeley. "But when you add them up, they are having an impact on outpatient prices and Affordable Care Act premiums," he said. "I call it conglomerate care." For instance, Northern California, where a few large health systems dominate the market and own many physician practices, has become the most expensive place in the country to have a baby.

The percentage of California primary care physicians in practices owned by hospitals increased from 26 percent in 2010 to 38 percent in 2016, the study found. For the same period, the percentage of specialists in such practices jumped from 20 percent to 54 percent. A similar wave of hospital-physician consolidation has occurred nationally. From 2010 to 2016, the national share of office-based physicians who worked in hospital-owned organizations has increased from 30 percent to 48 percent, according to Scheffler and his co-authors.

Not surprisingly, hospital and physician groups defend these mergers as good for patients, saying they help coordinate care that is often fragmented, duplicative and wasteful. They say the deals enable them to deliver care that's less expensive and to negotiate more effectively with giant insurance companies and that the *Health Affairs* study is flawed.

But critics of consolidation say that as large health systems gain market power, they can dictate where patients go for expensive tests and procedures. Some hospitals tack on "facility fees" for outpatient care, which boosts costs even further.

(Likely scenario: IPA doc sends patient to unaffiliated lab for blood tests and free-standing outpatient center for colonoscopy; cost of X. IPA doc becomes hospital owned doc. Patient now sent to hospital lab and hospital owned outpatient center: cost of X+Y.---Ed.)

Melnick co-authored a separate paper in Health Affairs, also out Tuesday, that described how a steady erosion of competition among hospitals in California has contributed to rising health care costs.

The prices paid by health plans to California hospitals increased by 238 percent from 2001 to 2016 — despite a 10 percent drop in the volume of care for commercially insured patients over that same period.

Scheffler said his study didn't examine whether the quality of care had improved under hospital-controlled physician practices. He said, however, that the evidence of any quality improvement is thin so far, and he challenged providers to make their case. ❖

Sacrifice and Empathy

Moustapha Abou-Samra, MD, Associate Editor

I wrote in this newsletter a few months ago about sympathy, empathy and compassion and concluded that "it is difficult to be empathetic to people that have gone through horrendous suffering, because it is simply impossible to know what they are going through and how they are feeling."

Recently, I went through a profoundly moving experience that confirmed this conclusion.

Joanie and I visited Normandy, France, in August. We had a wonderful trip and enjoyed a beautiful part of France that is not what you typically experience in Paris. With the exception of our visit to Le Mont Saint Michel that was over run by tourists, there were no crowds. The countryside is beautiful, the people are friendly and welcoming, the steep history is noticeable everywhere you go, people do eat locally sourced vegetables and fruits, and they do enjoy dining slowly and in an unrushed manner. And the Beaches are breathtakingly gorgeous and serene, particularly when viewed from the amazingly steep cliffs that overlook the English Chanel.

Yes, of course we visited Omaha Beach and the American Cemetery in Normandy, where more than 10000 American service members are buried.

The contrast between the empty, peaceful and quiet beaches and what happened on D-Day is stark, almost deafening. I kept thinking of Spielberg's movie, Saving Private Ryan. I remembered the loud explosions that filled the movie theater and how uncomfortable I felt, as I did not know how to predict the next explosion and its resulting destruction and death of the many young Soldiers and Marines. Thousands died in a few hours.

I tried as hard as I could to put myself in these young soldiers' shoes. They were our Heroes, but they must have been petrified. Did they know what they were about to face? And how about their families? Separated by several thousand miles, they must have felt helpless and so scared. And how about when they received the news of their loss?

I, simply, could not imagine myself in their shoes. I tried, but I couldn't. Instead, I kept praying that our days of being involved in foreign wars will soon be over.

I realize that the D-Day landing changed the course of WWII and eventually brought Victory to the Allies against Tyranny. But I couldn't help thinking of how many lives were cut short.

The visit to the American Cemetery in Normandy was very moving and also instructive.

Before entering the actual cemetery, one is ushered to the visitors' center; it is full of information, photographs, quotes and historical facts that I found compelling. As one leaves the visitors' center, one passes by an infinity pool that seems to empty over the cliffs; very well designed.

The Cemetery is located on a large expanse of land that hugs the cliffs, adjacent and to the southwest of the visitors' center. The grounds are beautifully manicured and the rows after rows of grave markers, arranged in sections, surround a peaceful reflecting basin flanked by two large American flags. At one end there is a majestic memorial and at the other a tastefully designed small chapel. I stopped by a few graves, read the names of the Heroes, their hometowns, the divisions in which they served and their ages. I found it difficult to push my tears back.

I learned that the graves were assigned randomly, not in an alphabetical, or geographical order and certainly not by rank. So a private may have been buried next to a general and a kid from California next to someone from Wisconsin.

We were fortunate to witness the lowering of the flags, a ceremony that takes place at 5PM sharp every day. They start with the flag on the right, closest to the English Channel, and quickly move to

the left. Only the left flag is lowered to the sound of "taps". As anticipated the small crowd was quiet and respectful. Joanie and I were moved and felt at once proud and very sad.

We noted with interest and some disappointment that the personnel who performed the ceremony were French, not American service people as we had somehow assumed. The man who lowered the flag was a handsome, tall and muscular uniformed security guard, and he did a wonderful job handling the flags as if they were those of his own country. Two also uniformed women, who received the flags as they got close to ground level and folded them in the typical triangular fashion, assisted him. They did it methodically and respectfully. They, then, handed them to an American civilian who I gather worked there.

I was expecting a service person to appear with his bugle when it was time to play "taps." None was in sight. Instead a loud speaker did the honors. It was a solemn and respectful moment.

Our federal Government spends quite a bit of money on things related to war. And lot of it, I have to say, is wasted. Here, let me admit that this is my own opinion. But I strongly feel that this ceremony honoring the more than 10000 Heroes who lost their lives on foreign shores, Heroes who gave the ultimate sacrifice so that we may continue to live in the Land of the Free, deserve to have American service personnel give them the honors. And yes, a real person playing "taps" is the least we can do to pay our respect. ❖

CANS MISSION STATEMENT

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

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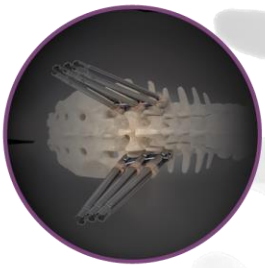

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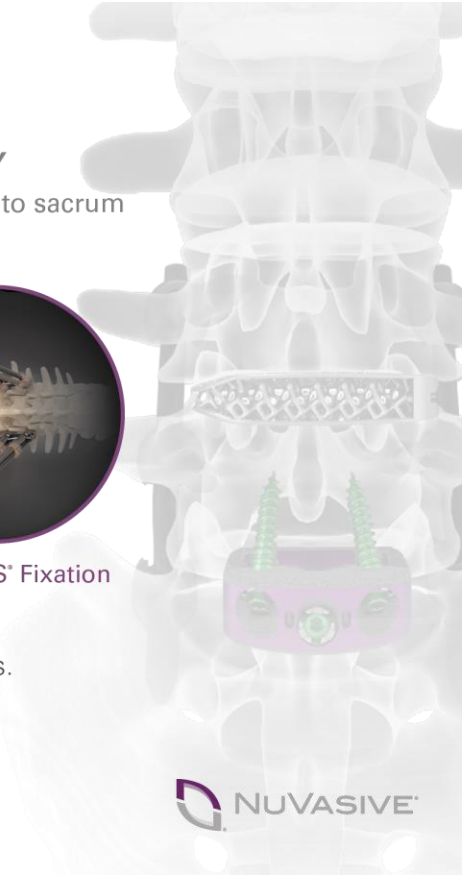

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SAVE the DATE!

CANS Annual Meeting January 18 – 20, 2019

Residents: Please consider submitting an abstract to your Program Director for consideration to present in Los Angeles!
Active Members: Please mark your calendars for this meeting!
Exhibitors: Please consider supporting this meeting! Contact, emily@cans1.org or 916-457-2267 for more details!

Brain Waves

Deborah C. Henry, MD, Associate Editor

My son left a draft of the first page of his college application personal statement in my office on the copier machine, and I could not help but take a look. Part of the essay was of the push in Newport Beach Harbor High School to play sports and as a result how the arts at the school pale in comparison. Indeed, at his high school, the band numbers about 50 people in size. For a school of nearly 3000, this is a sad commentary on the support of the arts in many of our high schools.

A few weeks before stumbling on my son's first page of his essay, I was reading an article by Tommy John in the AARP magazine. He begins by asking what do you think of when you hear the words "Tommy John"? If you are like me, you think of the surgery to repair the ulnar collateral ligament that was pioneered by Frank Jobe of the infamous Kerlan-Jobe Clinic in Los Angeles. Tommy John, the pitcher, had this surgery in 1974, almost half way through his 26-year career during which he won 288 games and was a four-time All Star. A decade later, the operation was called Tommy John surgery simply because that was easier to say and more recognizable than ulnar collateral ligament repair. Once a rare operation, Mr. John states that 57% of his namesake surgeries are now done on teenagers between the ages of 15-19. Fifteen percent of these kids will never fully recover.

Youth sports are at least a fifteen billion dollar yearly business. According to the article, ACL tears in children have increased at an annual rate of 2.3% over the past twenty years, and the concussion rate is now 1 in 5. Some of this increase in numbers is thought to be from young athletes committing to only one sport year-round rather than cross-training in multiple activities.

From my viewpoint as a parent, I've seen the push for sports, from attending a freshman meeting of parents where the principal (of whom I have the utmost respect) highly recommended that all freshman become active in sports throughout their high school career (no mention of the arts), to my neighbors who drive their kids to early morning water polo and swim practice so that they may be scholarship ready, to the transfers from my church to Mater Dei as they have state championship athletic programs, especially in football and basketball.

My son has received a few college brochures highlighting the arts. Stanford touted its music program. Brown and a few other universities will allow him to submit an artistic portfolio. But somehow I think if he were an elite athlete, the schools would be clamoring for him to come. There was a day when parents dreamed of their child becoming a doctor, a lawyer, or President of the United States. Now the dream is a star-athlete. ❖

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!

The requirements for reporting encounters with patients bearing the diagnosis of Parkinson's disease, which commenced on July 1st of this year, are detailed in the pdf a link to which is :

CDPH - Health Information Exchange Gateway

Tidbits from the Editor

CANS Board doing its Duty

CANS Board of Directors met on the 29th of September in the LAX area. The meeting was attended by Drs. Abou-Samra, Asgarzadie, Blaskiewicz, Blumenfeld, Chen, Colohan, Gantwerker, Henry, Holly, Kissel, Kim, Krel, Mummaneni, Page, Pendharkar, Ratliff, Siddiqi, Smith and Wade. Participating via phone; Drs. Dhall, Harraher, Linskey and Lippe.

Notable items addressed were:
(1) the program for the January 2019 annual meeting which President Holly has fleshed out (presented in the meeting attachment to this newsletter email),
(2) the probable locale for the 2020 annual meeting in a Sonoma valley hotel
(3) the approval of membership for three previous members returning to the fold: **Federico Moure** from Oakland, **Mark Liker** from Valencia and **Griffith Harsh** at UC Davis
(4) nominations for next year's BOD elected offices namely **Mark Linskey** for President-Elect, **Javed Siddiqi** for 1st VP, **Kimberly Page** for 2nd VP, **Sanjay Dhall** for Director-North and **Brian Gantwerker**, **Esther Kim** and **Don Blaskiewicz** for Directors from the South.
(5) awarding the 2019 Pevehouse Award for Distinguished Service in Neurosurgery to **Lawrence Pitts** and the George Ablin Distinguished Public Serve Award to **Katie Orrico** (the CEO of the AANS/CNS Washington Committee).

Finally, the BOD discussed the 18 resolutions to be presented at the CSNS meeting on October 5th in Houston just before the CNS meeting and took the positions indicated on the list following.

RESOLUTION I (CANS BOD voted to support)
Title: A Neurosurgical Call for Gun Control
Submitted by: Gary Simonds MD MHCDS, Cara Rogers DO
WHEREAS, the incessant incidence of gun violence in the United States threatens the fabric of our society; and
WHEREAS, neurosurgeons are acutely aware of the lethality of firearms and of the appalling nervous system injury inflicted by gunshot wounds to the head and spine; and
WHEREAS, neurosurgeons are the societal "stewards" of the nervous system and should proactively seek to protect said system rather than solely respond to its injury; and
WHEREAS, the pro and anti-firearm debate is so polarized that rational compromise is unlikely to occur without political pressure exerted by the most respected people and institutions of the society; and
WHEREAS, Neurosurgery is a deeply respected representative of the field of medicine, and its "weighing-in" on the subject of gun-violence might carry some positive impact; and
WHEREAS, enough is enough; therefore
BE IT RESOLVED, that the CSNS urges the CNS and AANS to prepare a joint position statement in support of stricter gun control laws.

RESOLUTION II (Support)
Title: Advanced Leadership Development for CSNS Resident Fellows
Submitted by: Ramana Gorrepati, Andrew E. Wakefield, Clemens M. Schirmer and NE Quadrant
WHEREAS, leadership development for both organized neurosurgery and local leadership on a practice, institutional and state level for all segments of the neurosurgical life-cycle is a core value of the CSNS; and
WHEREAS, the CSNS resident fellowship successfully aims to develop a basic level of leadership in the recipients; and

WHEREAS, graduates from the current fellowship do not have an avenue for systematic leadership development or further involvement in organized neurosurgery; and
WHEREAS, post-residency neurosurgeons of all ages and interest levels are not eligible to the leadership development opportunities offered by the CSNS socioeconomic fellowship; and
WHEREAS, both parent organizations, namely the CNS, have identified leadership as a part of their core mission and developed successful multi-tiered leadership courses with a competitive selection process; therefore
BE IT RESOLVED, that the CSNS leadership work with the CNS to develop a leadership development pipeline involving both CSNS fellows and CNS sponsored candidates with reciprocal opportunities and participation in the development opportunities of the CSNS socioeconomic fellowship and some or all aspects of the CNS leadership courses for selected candidates; and
BE IT FURTHER RESOLVED, that nominations of candidates utilize best practices demonstrating both institutional commitment from CSNS leadership and multi-point mentor- and sponsorship; and
BE IT FURTHER RESOLVED, that CSNS develop a framework and principles that describes how to harness the skillset of successful graduates of this extended leadership development process in its own leadership recruitment.

RESOLUTION III (Support)
Title: A Joint Committee on Physician Wellness
Submitted By: Gary Simonds, MD, MHCDS, Cara Rogers, DO
WHEREAS, there is an expanding body of literature that suggests 50 to 70 percent of neurosurgeons experience components of burnout and other maladaptive responses to work and life stressors; and
WHEREAS, studies have demonstrated that physicians suffering from burnout demonstrate higher incidences of feelings of futility, harmful maladaptive behaviors, substance abuse, marital discord, and serious mental illness; and
WHEREAS, studies have demonstrated that physicians suffering from burnout demonstrate higher rates of cognitive decrement, processing difficulties, errors in judgment, treatment-related complications, loss of empathy, and litigation; and
WHEREAS, implicitly, neurosurgeons suffering from burnout and other maladaptive responses to work and life stressors are at risk of providing compromised care for their patients; therefore
BE IT RESOLVED, that the CSNS recommends to its parent bodies that a joint AANS-CNS Physician Wellness Committee is instituted; and
BE IT FURTHER RESOLVED, that a Joint AANS-CNS Physician Wellness Committee would focus specifically on studies, strategies, actions, and policies that seek to ameliorate the effects of burnout and other psychological distress, and promotes physical, mental, and emotional wellness in practicing neurosurgeons and neurosurgical trainees.

RESOLUTION IV (Support)
Title: Evaluating the Ramifications of a Shift in the Neurosurgical Workforce
Submitted By: Gary Simonds MD, MHCDS, Cara Rogers DO
WHEREAS, the SNS Committee on Advanced Subspecialty Training (CAST) now accredits various neurosurgical subspecialty fellowships (enfolded and post-graduate); and
WHEREAS, for all intents and purposes, the ABNS now offers the opportunity for two thirds of its certifying oral examination to be taken in a neurosurgical subspecialty; and
WHEREAS, the ABNS plans to offer acknowledgement of subspecialty "focused practice" in those subspecialists it certifies, but no such additional acknowledgement of neurosurgeons who plan to practice general/acute care neurosurgery; and
WHEREAS, the additional recognition and sanctioning of neurosurgeons in various subspecialties risks fragmentation of the specialty; and

WHEREAS, the additional recognition and sanctioning of neurosurgeons in various subspecialties may bestow upon neurosurgical subspecialists an unfair competitive edge over general/acute care neurosurgeons in various healthcare markets; and
WHEREAS, the additional recognition and sanctioning of neurosurgical subspecialists will act as a counter-incentive for trainees to go into general/acute care neurosurgery; and
WHEREAS, it is not clear that there is a strong consensus amongst the rank and file behind division of the neurosurgical workforce into subspecialties, or behind the potential substantial loss of general/acute care neurosurgeons from the neurosurgical workforce; and
WHEREAS, the sub-specialization of the neurosurgical workforce may substantially increase the number of neurosurgical providers needed to cover all the elective, acute care, and call needs of a given healthcare market (to affect broad-based, around the clock, neurosurgical coverage); and
WHEREAS, it is not clear that many healthcare markets can support an array of neurosurgical subspecialists with strictly defined capabilities and care proclivities; and
WHEREAS, the sub-specialization of the neurosurgical workforce may substantially drive up the cost of care, without necessarily improving the overall level of care (references 1,2,3,4,5,6 below); therefore
BE IT RESOLVED, that the CSNS requests of its parent bodies an open study of, and discourse on, the socioeconomic
ramifications of a potentially dramatic shift in the neurosurgical workforce to subspecialists.

RESOLUTION V (Oppose)
Title: CAST Accreditation for General and Acute Care Neurosurgery Fellowship Programs
Submitted by: Gary Simonds MD MHCDS, Cara Rogers DO
WHEREAS, the SNS Committee on Advanced Subspecialty Training (CAST) accredits various neurosurgical subspecialty fellowships (enfolded and post-graduate); and
WHEREAS, the SNS CAST offers no accreditation for additional general neurosurgery or acute care neurosurgery (trauma, emergency neurosurgery) fellowship training; and
WHEREAS, the additional recognition and sanctioning of neurosurgeons in various subspecialties risks inference of implicit superiority of neurosurgical acumen in those who have undergone CAST accredited fellowship training (even if completed during residency training); and
WHEREAS, the additional recognition and sanctioning of neurosurgeons in various subspecialties risks fragmentation of the specialty; and a loss of a core group of general/acute care neurosurgeons; and
WHEREAS, CAST recognition and sanctioning of enfolded or post-graduate general/acute care neurosurgery fellowship training would potentially help "level the playing field" and dampen a competitive edge that would be inherently bestowed upon surgeons with subspecialty fellowship training; and
WHEREAS, CAST recognition and sanctioning of enfolded or post-graduate general/acute care neurosurgery fellowship training would potentially encourage more neurosurgeons to maintain broad-based and acute care skills, relaxing the strain on areas of critical neurosurgeon shortage or those that cannot support multiple arrays of neurosurgical specialists; therefore
BE IT RESOLVED, that the CSNS encourages its parent bodies to study and discuss with the SNS and the ABNS the relative merits of granting CAST accreditation for enfolded and post-graduate fellowships in general/acute care neurosurgery.

RESOLUTION VI (Neutral—await debate)
Title: Towards a More Vibrant and Deliberative CSNS National Meeting
Submitted by: Gary Simonds MD MHCDS, Cara Rogers DO
WHEREAS, the CSNS national biannual meetings are at risk of drifting away from their intended purpose of serving as a forum for resolution testimony and debate; committee interface; face to face open discussion and debate on socioeconomic issues affecting the profession of Neurological Surgery and its

patients; and the addressing of issues and concerns raised by the various Sate Neurosurgical Societies; and

WHEREAS, foreshortening of the CSNS National Meetings runs the risk of subjecting their proceedings to a sense of time compression and thus a loss of opportunity for relaxed open discourse, information transfer, and debate - both formal and informal; and

WHEREAS, the argument can be made that during this era of exceptional medical socioeconomic flux and upheaval, the CSNS meetings take on critical importance to the profession and should be longer and richer, and widely open to spirited debate; and

WHEREAS, CSNS committee analysis of resolutions has been principally shifted from face to face discourse to remote, often poorly attended, phone meetings; and

WHEREAS, the assignment of resolutions to specific CSNS committees is expressly intended for the "research" and development of "specific information" relevant to the resolutions, not for final decision or vote upon the adoption (or lack thereof) of the resolutions, prior to open testimony and discussion before the Reference Committee; and

WHEREAS, perhaps in the interest of expediency, the conduct of the Reference Committee Open Hearing (during the first Plenary Session) has shifted from the "gathering of testimony from any and all parties interested in rendering an opinion on each resolution", to essentially a registration of up-down votes on each resolution, prior to full open testimony from resolution authors and delegates/appointees/experts/assigned committees/interested parties - as is prescribed by the CSNS Rules and Regulations; and

WHEREAS, the Reference Committee may be unduly influenced in their final recommendation on a given resolution by the premature rendering of various committees' up-down sentiments on said resolution, formulated prior to hearing full Reference Committee Open Hearing testimony from all interested parties on the resolution (e.g. typical Reference Committee justification of their recommendation on a resolution: "we recommend rejection of the resolution – 5 committees spoke against it and only the author and the Workforce Committee spoke in favor of it); and

WHEREAS, many of the CSNS Officers and Executive Committee Members hold other national neurosurgical committee and leadership roles, potentially inhibiting a desire to expand the CSNS meeting duration due to scheduling conflicts; and

WHEREAS, many important, hotly debated, accepted and referred-to-committee resolution issues seem to disappear from all further discussion in subsequent CSNS national meetings potentially disincentivising future resolution generation; and

WHEREAS, more of the CSNS "business" – that is, idea generation, resolution development, socioeconomic issue discussion and debate, state society issue and concern analysis, committee growth and activity, resolution discussion and debate and more – is being shifted to remote electronic/phone interfaces; and

WHEREAS, some of the best socioeconomic idea generation occurs from face to face discourse in committee and caucus meetings, in the plenary sessions, and in informal gatherings at the CSNS National Meetings; and

WHEREAS, open face-to-face discourse between members is the only justifiable reason for holding in-person CSNS National Meetings; therefore

BE IT RESOLVED, that the CSNS bi-annual meeting is expanded to two full days; and

BE IT FURTHER RESOLVED, that ample time in the CSNS National Meetings is given to committee meetings, plenary sessions, resolution testimony and debate, informal gatherings, caucus meetings, and various sub-committee and ad hoc committee meetings; and

BE IT FURTHER RESOLVED, that the conduct of the Reference Committee Hearing (during the first plenary session) is restored principally to resolution testimony and the presentation of related information; and

that committee up-down recommendations are deferred to the Resolution Debate Session (during the second plenary session); and
BE IT FURTHER RESOLVED, that at each CSNS National Meeting, a summary is presented to the body on the status and progress of all active resolutions, and that this summary is archived on the CSNS website; and
BE IT FURTHER RESOLVED, that CSNS Officers and Executive Committee Members reasonably limit their external leadership commitments and activities during their CSNS leadership tenures, or at least commit to giving highest priority to the needs of the CSNS and its national meetings.

RESOLUTION VII (Oppose)
Title: The Creation of a CSNS State Resident Delegate Position
Submitted by: D. Ryan Ormond, M.D., FAANS
WHEREAS, the CSNS has been involved in the socio-economic education of residents for many years; and
WHEREAS, leadership development is a central core value of the CSNS; and
WHEREAS, much of the leadership in Neurosurgery has come through the CSNS; and
WHEREAS, there is a benefit to provide additional leadership training and mentorship within the CSNS, AANS, CNS and Washington committees for neurosurgery residents; therefore
BE IT RESOLVED, that the CSNS create a new position of state resident delegate, with a vote in the CSNS equal to a state delegate, representing one delegate for every 50 ACGME-accredited neurosurgery resident positions in the state; and
BE IT FURTHER RESOLVED, that states no longer count residents toward their total practicing neurosurgeon count for delegate number, since residents will now be represented by their own state resident delegate.

RESOLUTION VIII (Oppose)
Title: Teleconferencing of Proceedings of the Council of State Neurosurgical Societies
Submitted by: Michael Karsy, Darian Esfahani
WHEREAS, the Council of State Neurosurgical Societies (CSNS) serves an important role in representing the socioeconomic interests of neurosurgeons;
WHEREAS, many neurosurgeons have limited availability to participate in and follow the proceedings of CSNS meetings; therefore
BE IT RESOLVED, that the CSNS begin teleconferencing of the biannual meeting proceedings including discussion of resolutions, meeting updates, and specific topic lectures; and
BE IT FURTHER RESOLVED, teleconferencing be provided free of charge to registered neurosurgeons or allied health providers to facilitate the mission of the CSNS; and
BE IT FURTHER RESOLVED, a study of telecast viewers be evaluated within 1 year of starting the telecast to gain insight into how the CSNS can better represent neurosurgeons.

RESOLUTION IX (Support)
Title: A Call to Prior Authorization Reform
Submitted by**:** Laila M. Mohammad, Kristopher T. Kimmell, and the Patient Safety Committee
WHEREAS, prior authorization (PA) is a cost-control process requiring health care providers to obtain approval from health insurers before performing a service; and
WHERAS, this process is overused, creates significant administrative burden, delays in patient care, and increased overhead costs for practices1-3; and
WHEREAS, there is no current data on denial, delay, and approval rates or guidance on PA; and
WHEREAS, many PA requests for medications or imaging studies are ultimately approved but can result in delays in patients receiving appropriate therapy or diagnostic testing, which is a significant patient safety issue; and

WHEREAS, multiple medical societies, led by the AMA, have identified rising PA rates4 as a major factor in physician burnout as well as impacting patient care; therefore
BE IT RESOLVED, that the CSNS study the scope of services subject to prior authorization and data on their approval/denial rates; and
BE IT FURTHER RESOLVED, that the CSNS work closely with the Washington Office to advocate for meaningful change in unnecessary PA policies from insurers; and
BE IT FURTHER RESOLVED, that the CSNS provide educational materials to members providing standard guidance on prior authorization processes.

RESOLUTION X (Support)
Title: A Call for Enhanced Education on Cybersecurity for Neurosurgeons
Submitted by: Kurt A. Yaeger, Kristopher T. Kimmell, and the CSNS Patient Safety Committee
WHEREAS, security of health information technology (IT) is principally guided in the U.S. by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act1. The Act serves to coordinate U.S. health IT strategy and provide general guidelines for electronic security, specifically with regard to electronic medical records.
WHEREAS, health IT security breeches in the U.S. has widespread impact, affecting over 90% of healthcare organizations and costing $6 billion2. Up to 45% of incidents are caused by criminal activity, and can result in proliferation of sensitive patient medical data.
WHEREAS, the widespread proliferation of electronic medical records, internet-based medical communications platforms, and wireless implanted medical devices has led to an increasing rate of medical cybersecurity breeches affecting both patients, physicians, and institutions.
WHEREAS, unauthorized access to wireless medical devices exposes sensitive patient medical data and potentially threatens patients with direct harm by means of altering neurophysiological parameters, overdose, or deactivation.
WHEREAS, increasing utilization rates of implanted wireless medical devices for neurosurgical conditions (i.e. neurostimulators, intrathecal drug pumps) leaves a growing patient cohort vulnerable to malicious cybersecurity threats.
BE IT RESOLVED, that the CSNS assesses the vulnerability of neurosurgical patients to a growing risk of cybersecurity threats, specifically by studying the current gaps in medical data and neurosurgical device security; and
BE IT FURTHER RESOLVED, that the CSNS works to raise awareness among neurosurgeons about the potential for external cybersecurity threats on both patient medical data and implanted devices, such that they may in turn educate their patients of these risks and further advocate industry and political leaders for improvements in patient safety.

RESOLUTION XI (Support)
Title: Gainsharing in Neurosurgery
Submitted by: Megan Jack, MD, PhD; Sarah Woodrow, MD; Ann Parr, MD, PhD; Justin Singer, MD; Cati Miller, MD
WHEREAS, gainsharing is a fiscal tool which has the potential to improve efficiency, increase quality, and reduce cost[1]; and
WHEREAS, gainsharing may align physician and hospital interests and result in incentives to use cost-effective instruments or techniques; and
WHEREAS, a percentage of the cost-saving benefits produced from gainsharing may be allocated to physicians based on the physician's effort to reduce the healthcare cost to the hospital[2]; and
WHEREAS, historically, the U.S. government has prevented hospital-physician gainsharing; and
WHEREAS, recently the Health and Human Services Office of the Inspector General (OIG) no longer imposes sanctions and penalties for certain healthcare gainsharing initiatives[3]; and

WHEREAS, the use of gainsharing in neurosurgery remains largely unknown; therefore
BE IT RESOLVED, that the CSNS develop a survey to learn about the use of gainsharing initiatives by practicing neurosurgeons and other administrators identified through NERVES
BE IT FURTHER RESOLVED, that the CSNS will generate a white paper from the data gathered from the survey regarding the current use of gainsharing in neurosurgery

RESOLUTION XII (Support)
Title: Development of the next generation CSNS web presence
Submitted by: Clemens Schirmer, MD, Scott Simon, MD, and Omar Zalatimo, MD
WHEREAS, the CSNS mission is to serve as a resource for socioeconomic knowledge and education; and
WHEREAS, current custom web platform, while well-conceived and executed, severely limits flexibility to address current and changing needs of the CSNS as well as new ideas about design and organization; and
WHEREAS, in the past delegates and leadership have voiced desire for significant expansion of the website functionality; and
WHEREAS, current usage numbers, see attached, depict a limited ongoing demand for a highly functioning CSNS website; therefore
BE IT RESOLVED, that the CEC website subcommittee develop a survey to the delegates and membership of the parent organizations to define the different pain points a future CSNS web presence would aim to address; and
BE IT FURTHER RESOLVED, that the CEC website subcommittee work with parent organization technical staff to develop a set of technical requirements, scope of work, deliverables and timeline that may form the basis of an RFP process and magnitude estimation for both creation and maintenance of an updated and higher functioning web presence.

RESOLUTION XIII (Support)
Title: Evaluation of the Non-Compete Clause
Submitted by: Vincent Y. Wang, on behalf of the Medical Practice and Medico-Legal Committee
WHEREAS, the number of neurosurgeons engaged in solo practice has been declining and increasingly, neurosurgeons are employed as part of a large multi-subspecialty group or directly by hospitals, and
WHEREAS, non-compete clause is a frequent component of employment contract in neurosurgery, and
WHEREAS, there is significant variability in the terms of non-compete clauses such as duration, geographic variation, buy-out provision, subspecialty overlap (i.e., no endovascular work allowed) and
WHEREAS, different states have variable enforcement consequences of the non-compete clause, therefore,
BE IT RESOLVED, that CSNS develop a survey to understand the prevalence and general terms of non-compete clause among practicing neurosurgeons, and
BE IT FURTHER RESOLVED, that CSNS develop education resources for neurosurgeons to understand the different state's enforceability of a non-compete clause in a physician contract.

RESOLUTION XIV (Support)
Title: **Exploration of the Effect of Restrictive Pain Medication Prescribing Laws on Neurosurgical Post-Operative Patient Care**
Submitted by: Steven Tenny, Andrew P Gard, Michael Karsy, Karin Swartz
WHEREAS, there has been a drive to limit opioid pain medication addiction and misuse in the United States; and
WHEREAS, neurosurgical patients frequently require adequate post-operative pain control with opioid and other pain treatment modalities;

WHEREAS, new limits from the Centers for Medicare and Medicaid Services have proposed arbitrarily limiting new prescriptions 90 mg (effective 1/1/19), and some states are legislatively limiting a physician's ability to prescribe pain medications in adequate amounts to control post-operative pain,
BE IT RESOLVED, that the CSNS assign a task force to create a work product on the effects of legislation on opioid medication prescriptions affecting pain control in the neurosurgical post-operative patient.

RESOLUTION XV (Support)
Title: Current Practice Patterns and Transfer Appropriateness of Neurosurgical Trauma in Underserved and Low Resource Areas and the Integration of Telemedicine Services
Submitted by: Ramana Gorrepati M.D., Christopher Shank M.D., Vincent Wang M.D., Ph.D.
WHEREAS, despite adequate neurosurgeon coverage in many urban areas, a majority of the United States is underserved with some states having on average 0 to 2 neurosurgeons per every 100,000 individuals1; and
WHEREAS, there is an inherent responsibility to provide basic neurosurgical care in a timely manner to our community; and
WHEREAS, the demand for neurosurgical services will only expand given the aging baby boomers and the rate at which retiring neurosurgeons outpaced recent graduates; and
WHEREAS, in current population based models and capitation systems, there is a trend toward increasingly narrow networks that will disproportionately affect select geographic regions namely more underserved regions of the United States; and
WHEREAS, in line with the mission of the CSNS to serve as a resource of socioeconomic knowledge and to positively influence and affect socioeconomic policy to the benefit of our patients and our profession; therefore
BE IT RESOLVED, that the CSNS study the current practice pattern in triaging neurosurgical traumas and the use of telemedicine and consulting services in underserved hospital settings to manage these complex patients, and where appropriate the costly transfer of care to larger centers with neurosurgical expertise; and
BE IT FURTHER RESOLVED, that the CSNS generate a white paper or similar publication to bring attention to the subject

RESOLUTION XVI (Support)
Title: Encouraging timely payments to providers
Submitted: Owoicho Adogwa, Karin Swartz, Neil Majmundar, Joseph S. Cheng, and Work Force Committee
WHEREAS, insurer payment delays to providers contribute to patient and provider anxiety. Many states enacted "prompt pay" statutes requiring insurance companies to pay claims within a specified number of days or be subjected to a penalty; and
WHEREAS, "prompt pay" applies only to "clean claims" defined by Medicare as claims having no defects, impropriety, or special circumstances-- including incomplete documentation that delays timely payment; and
WHEREAS, the statutes are ambiguous, vary from state-to-state, and lack clear and consistent definition of what constitutes a "clean claim"; and
WHEREAS, the current statutes have been unenforceable because of problems with "clean claims" definitions; therefore
BE IT RESOLVED, the CSNS encourages collaboration between the AANS/CNS, AMA, and individual state legislatures to specifically clarify what constitutes a "clean claim" under each individual state's "prompt pay" statutes.

RESOLUTION XVII (Oppose)
Title: Creation of a National Resident Attrition Survey

Submitted by: Michael D. White, B.S., Nitin Agarwal, M.D., Susan Pannullo, M.D., Lola Chambless, M.D.
WHEREAS, resident attrition within neurosurgical training creates a profound burden for both residency programs and the individuals leaving residency1,2; and
WHEREAS, neurosurgery has been found to have one of the highest rates of resident attrition, second only to general surgery3-7; and
WHEREAS, according to data obtained from the AANS, two-thirds of residents leaving their residency program leave the field of neurosurgery altogether; and
WHEREAS, there has yet to be an initiative to gather data from those who left in order to determine risk factors for attrition and areas within neurosurgical training that can be improved; therefore
BE IT RESOLVED, that the CSNS create a national survey to send to former neurosurgery residents who left a training program identifying reasons for leaving and areas of improvement to prevent future attrition; and
BE IT FURTHER RESOLVED, that the CSNS conduct a study based on the survey results to statistically analyze risk factors significant for attrition in order to identify early at-risk residents and provide better support for those residents, in an effort to lessen the attrition rate in neurosurgical residency programs.

RESOLUTION XVIII (Oppose)
Title: Barriers to Participation in the Quality Outcomes Database
Submitted by: Brett Youngerman and Ann Stroink
WHEREAS, there is growing demand amongst patients, physicians, government, and private insurers for measurement of health outcomes and accountability for overall value;1 and
WHEREAS, individual surgeons will increasingly be held responsible for the quality of care they provide and be expected to analyze and improve methods of care;1 and
WHEREAS, surgical specialty organizations have the appropriate expertise and capacity to define clinically meaningful risk-adjusted outcomes measures, develop systems for data collection, and establish benchmarks to facilitate local quality improvement;1 and
WHEREAS, the NeuroPoint Alliance Quality Outcomes Database (QOD) is the only clinical data registry supported by the American Association of Neurological Surgeons (AANS), Congress of Neurological Surgeons (CNS), the American Board of Neurological Surgeons (ABNS), the Society of Neurological Surgeons (SNS), the Neurosurgery Research & Education Foundation (NREF), and the AANS/CNS Section on Spine & Peripheral Nerves;2 and
WHEREAS, the QOD is the largest spine registry and one the largest cross-specialty clinical registries in North America;2 and
WHEREAS, participation in a Qualified Clinical Data Registry (QCDR) enables physicians to meet reporting requirements under the Center for Medicare and Medicaid Services (CMS) Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) and avoid a negative payment adjustment;3 and
WHEREAS. the MIPS potential negative payment adjustment will increase to 9% by 2022, further increasing the financial pressure on surgeons to join a qualified registry;3 and
WHEREAS, early participation in QOD for MIPS reporting has been limited, with only 38 surgeons reporting across 7 practice groups in 2017;4 and
WHEREAS, QOD participants also benefit from using the registries to participate in structured quality improvement projects and studies, identify practice gaps through established benchmarks, negotiate with third party payers, and publish and analyze outcomes from national aggregate data;5 and
WHEREAS, there are numerous potential barriers to participation in QOD for many neurosurgeons, particularly those in smaller groups or non-academic settings, including the financial cost of participation, administrative and reporting burdens, and limited opportunity to analyze or publish data; and **REAS**, an unknown number of neurosurgeons participate in other spine-focused clinical registries including some that are not CMS-approved for MIPS (North American Spine Society (NASS) Registry) and

others that are industry run (SpineTRACK, run by NuVasive, and the Spine Institute for Quality Conservative Care: QCDR For Individuals (SPINE IQ), administered by Premier, Inc); and **WHEREAS**, the following medical specialty societies provide a qualified clinical registry at no charge to their members: American College of Surgeons, Society of Thoracic Surgeons, American Urogynecologic Society, American College of Rheumatology, American Society of Anesthesiologists, American Psychiatric Association; and the following societies offer a qualified registry for less than $300 per year per member: American Society of Plastic Surgeons, American Academy of Otolaryngology Head and Neck Surgery, American Society of Breast Surgeons, American College of Radiology, American Physical Therapy Association, American Society of Clinical Oncology, The College of American Pathologists;6 and
WHEREAS, numerous large research networks and clinical registries have begun interfacing with electronic health record systems for clinical data capture;7 and
WHEREAS, the NeuroPoint Alliance currently offers registries covering spine, neurovascular, and stereotactic radiosurgery but not other neurosurgical subspecialties; and
WHEREAS, limited participation in QOD negatively impacts the representativeness of the data and leads to a lost opportunity for all neurosurgeons to realize its benefits; therefore
BE IT RESOLVED, that the CSNS survey neurosurgeons to study factors related to participation in QOD and other registries, including demographics, practice characteristics, and barriers; and
BE IT FURTHER RESOLVED, that the CSNS, in collaboration with the NeuroPoint Alliance, AANS, and CNS, develop and publicize materials to educate neurosurgeons about their options for participating in a qualified registry, meetings MIPS reporting requirements, and avoiding a negative payment adjustment; and
BE IT FURHER RESOLVED, that the CSNS petition the AANS, CNS, and NeuroPoint Alliance to consider options for allowing all neurosurgeons to participate in a CMS-approved qualified clinical data registry, including:
1. exploring funding options to reduce the cost of participation in QOD;
2. developing a limited participation option to meet the requirements of a qualified registry;
3. expediting additional qualified registries that will allow neurosurgeons in all subspecialty areas to meet reporting requirements;
4. harmonizing QOD measures with those of other registries in which neurosurgeons participate;
5. working with commonly used electronic medical record and patient reported outcomes platforms to make approved measures more widely available and allow for data export in a format compatible with QOD.

Governor signs Scarlet "P" law; MBC strikes

Gov. Jerry Brown has signed the **Patient Right to Know Act,** making California the first state in the nation to require physicians to inform patients when regulators put them on probation for harming those under their care.

Under the new law, physicians on probation after July 1, 2019, must directly alert clients about their status before an appointment. The requirement applies to physicians who are on probation for hurting patients through sexual misconduct, drug abuse or improper prescribing, or if the physician has been convicted of a crime that involves harm to a patient. One suspects that those reasons for probation constitute a definite majority of the probation cases and we can expect the Medical Board of California to err on the side of inclusion in interpreting which of their causes for probation fulfill the criteria.

Surgeons, osteopaths, naturopathic doctors, chiropractors, podiatrists and acupuncturists are bound by the new law.

As the CANS newsletter has previously opined, implementation of this law will convert someone from an appropriately determined probation with restrictions and pathways for rectification to a pariah status that will destroy a career. Patients will flee rather than understand that probation includes restrictions and pathways for rectification and that they are safe with the doc as the MBC monitors and rectifies the doc's behavior.

Speaking of the Medical Board, Cheryl Clark of *Medpage Today* in its 9/5 issue, reports that the MBC has filed accusations against 9 docs as the result of the medical board's review of death certificates of patients who lethally overdosed in 2012 and 2013. The board matched those names in the state's prescription drug database to identify providers who prescribed opioids to those patients within 3 years of their death. Nearly 450 allopathic physicians, 12 osteopaths, and 60 nurse practitioners and physician assistants were targeted by expert reviewers for investigation and possible action. About half of the cases have been closed without further action; but in addition to the nine who have been formally accused of wrongdoing, dozens of others still face potential sanction.

The board's executive director, Kimberly Kirchmeyer, said the board intends to proceed with reviews of death certificates in subsequent years. Additional staff have been assigned to the project. A board spokesman said all nine accusations involve patients who died of opioids, although not all the documents made public to date reference a patient death. She noted that for most of the cases so far, a hearing has not yet been held so the physician has not been found guilty.

Good CURES info—not reproducible but good

By now, all CA neurosurgeons should be ready to consult the CURES system when prescribing opioids. The Medical Board of California has published several FAQ's which are worth reading. We can only provide a link to the FAQ's as trying to copy them and present them to our readers for convenient reading is prevented by the way the MBC published the FAQ's. One wonders if there is a position at the MBC entitled "VP in Charge of Obfuscation".
http://www.mbc.ca.gov/Licensees/Prescribing/CURES/CURES_FAQ.pdfem ❖

Quotation of the Month

When arguing with a fool, be sure he isn't doing the same thing
—anon.

Meetings of Interest for the next 12 months:

California Neurology Society: Ann. Meeting, October 5-7, San Diego, CA
CSNS Meeting, October 5-6, 2018, Houston, Texas
Congress of Neurological Surgeons: Annual Meeting, October 6-10, 2018, Houston, Texas
International Society for Pediatric Neurosurgery: Annual meeting, October 7-11, 2018, Tel Aviv, Israel
North American Spine Society: Annual Meeting, October 26-29, 2018, Los Angeles, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 6-9, 2018, Nashville, TN
Cervical Spine Research Society: Annual Meeting, December 6-8, 2018, Scottsdale, AZ
North American Neuromodulation Society: Ann. Meet., January 17-20, 2019, Las Vegas, NV
CANS, Annual Meeting, January 18-20, 2019; Sheraton Universal Hotel, Universal City/Burbank, CA
AANS/CNS Joint Cerebrovascular Section: Ann. Meeting, February 4-5, 2019, Honolulu, HI
Southern Neurosurgical Society: Ann. Meeting, February 20-23, 2019, Key Largo, FL
AANS/CNS Joint Spine Section: Annual Meeting, March 14-17, 2019, Miami Beach, FL
CSNS Meeting, April 12-13, 2019, San Diego, CA
AANS: Annual Meeting, April 13-17, 2019, San Diego, CA
NERVES Annual meeting, April 11-13, 2019, San Diego, CA
Neurosurgical Society of America: Annual Meeting, June 16-19, 2019, Banff, Alberta, Canada
Rocky Mountain Neurosurgical Society: Ann. Meeting, 2019, TBA
New England Neurosurgical Society: Annual Meeting, June 27-29, 2019, Brewster, MA.
Western Neurosurgical Society: Annual Meeting, November 8-11, 2019, Scottsdale, AZ

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. Langston Holly 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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