CANS newsletter

PQRS, VM & Neurosurgery: A Long Shinny up a Slippery Pole

Randall W. Smith, MD, Editor

Oh the Feds! How we love thee!

Readers may well be aware that the 2015 Medicare Physician Fee Schedule mandates changes in the Physician Quality Reporting System (PQRS) that will significantly affect every neurosurgeon. For the past eight years, PQRS has been a ***voluntary*** federal program that provided Medicare incentive payments to physicians that supplied quality data to the Centers for Medicare & Medicaid Services (CMS). However, beginning with the 2015 reporting year, these incentive payments will be replaced by a two percent cut in Medicare payments — which will be applied in 2017 to those who fail to satisfy PQRS reporting requirements ***this year***.

If you choose to play their game, then surgeon participation has gotten a lot harder. Physicians are now required to report nine different PQRS measures, from three unique quality domains, including one cross-cutting measure. Additionally, these measures must be reported in 50 percent of Medicare recipients. Selecting appropriate measures may prove difficult, as many PQRS metrics are not applicable to neurosurgery. It is important to report some measures, even if you can't easily reach the nine PQRS measure requirement. Under the Measures Applicability Validation (MAV) process, if you do the following you may not face a cut in 2017: Report some measures and report one cross-cutting measure.

Cross-cutting measures include general topics such as:

Medication Reconciliation;
Advance Care Planning;
Documentation of Current Medications;
Pain Assessment and Follow-up; and
Tobacco Use.

In addition to PQRS-related cuts, neurosurgeons face cuts — up to four percent — under the Value-Based Payment Modifier (VM), which measures quality ***and*** resource use/cost. Starting on January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) began applying the Value-Based Payment Modifier, or Value Modifier, to physician payments under the Medicare Physician Fee Schedule. The Value Modifier (VM) is designed to reward higher quality care delivered at lower cost, and requires CMS to apply the VM to specific physicians and groups of physicians as determined by the secretary of the U.S. Department of Health and Human Services beginning no later than January 1, 2015, and to all physicians and groups of physicians paid under the Medicare Physician Fee Schedule beginning no later than January 1, 2017.

In 2015, the VM applies to payments for physicians in groups with 100 or more eligible professionals. The maximum bonus that could be earned under the VM was 2.0 percent. The maximum penalty was 1.0 percent. 1,010 physician groups are subject to the VM in 2015 and out of the 1,010 groups, 14 received a bonus, 330 groups will be penalized, and 666 groups will be penalty/bonus neutral. Obviously a resounding success.

So between PQRS and VM, the total potential financial loss is six percent and this is before even considering any cuts under the Electronic Health Record meaningful use program.

The AANS, CNS, Senior Society and the Joint Spine Section have created the NeuroPoint Alliance (NPA) and have established a

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National Neurosurgery Quality and Outcomes Database (N²QOD) platform that Medicare will recognize as a qualified clinical data registry (QCDR). This will allow surgeons participating in N²QOD to satisfy their PQRS requirements. Unfortunately, signing up for the N²QOD is no easy task and is a bit expensive for the solo neurosurgeon or very small group. The sign up fee is $13,000 per year for three years for any practice (whether you are solo, a small group or a huge group). You also need to involve your primary hospital and get their OK on collecting data on your patients as a quality improvement program (no IRB approval necessary) and not a research proposal.

Each 13K allows you to chose up to three modules. The Lumbar module was formally launched and activated in February 2012. The Lumbar module is in its fourth year, and as of April 2015, there are nearly 15,000 patients enrolled across 46 participating centers. New centers are activated regularly and there are 64 contracted centers. The Cervical module was formally launched and activated in March 2013. The Cervical module is in its third year with over 4,500 patients enrolled across 33 centers. The Cerebrovascular module was launched in December 2014 and is the first subspecialty module separate from spine. The new module is now open to new sites. Data collection started in April 2015. The Deformity module was launched in December 2014 and focuses on non-complex deformity scoliosis. The module is now open to new sites.

The NPA says "Recognizing that not all practices have the resources to participate in extensive longitudinal registries, the NPA is working on offering a module designed to provide basic safety and quality data to the individual neurosurgeon while also satisfying public reporting requirements, including Maintenance of Certification (MOC) and PQRS (Physician Quality Reporting System)". Unfortunately they have been saying that for 2 years and still no NPA-Lite for small fry.

Since there are only two practice sites in California that are in the NPA program, it would seem that most of us are on our own if we want to report PQRS data in 2015. One could understand that a California neurosurgeon, looking at all this Federal gobbledygook, would just stop treating Medicare patients or simply decide to take the 10% cut and conduct business as usual. ❖

President's Message

This year I have appointed an ad hoc Program Committee to assist me in creating a provocative and meaningful offering for those attending our Saturday January 23rd session. This committee, chaired by Don Prolo, has been active over the last 6 months. We are moving ahead with the concept of a two part meeting. The first part will review the effects of Obamacare five years after implementation. Don has enlisted a number of knowledgeable speakers that will reveal who is really benefiting from the Affordable Care Act. The second half of the program will be more provocative and pursue the concept of CANS becoming a collective bargaining entity.

The specifics and details will be discussed at the upcoming Board of Directors meeting scheduled for late August in Sacramento. I would ask the membership to contact either myself (pkissel@pkisselneurosurgery.com) or Don Prolo (don@donaldprolo.com) with suggestions regarding topics or speakers of interest.

Phil Kissel, MD
CANS President ❖

In Memoriam

Ben Crue, a founding member of CANS, died February 2nd, 2015. Ben was born on May 22, 1925 in Rahway, New Jersey. He matriculated at the University of Chicago where he received a B.S. in 1945 and an M.D. in 1948. He interned at the USN Hospital in Oakland, California and had a year of general surgery and a year of neurosurgery training there before The Navy sent him to Huntington Memorial Hospital in Pasadena, California where he completed 2 years of neurosurgical training followed by further training at Yale and the Lahey Clinic.

A Navy assignment to San Diego Naval Hospital completed his 13-year tour of active duty. He then joined the private practice of Sheldon, Pudentz, and Freshwater in Huntington and stayed with them until 1960 when he joined City of Hope in Duarte, California, and established a neurosurgery service and a pain clinic. It was during his years at City of Hope that Ben became active in the pain world. His clinic was one of the earliest multidisciplinary pain clinics in the United States.

Ben was a founding member of the International Association for the Study of Pain (IASP) in 1973. He was one of the trio (Liebeskind, Loeser, and Crue) that initiated the Western U.S. Pain Society in 1975. He was a founding member of the American Pain Society (APS) and served as its second president. Ben and a few colleagues (including Phil Lippe) started what went on to become the American Academy of Pain Medicine (AAPM).

In 1985 he moved to Durango, Colorado and started the Durango Pain Rehabilitation Center from which he retired in 1993. In his 22 years of retirement, he was busy writing about his life, his thoughts on pain and its treatment, and the Mormon faith, which he had adopted in mid-life. A celebration of his life will be held on July 11, 2015, in Durango, Colorado. ❖

Guest Editorial

(Dr. Wohns founded NeoSpine, LLC in 2001 with $20 million of venture capital in order to develop a national network of outpatient spine surgery centers. Symbion, Inc. acquired NeoSpine in 2008, and Dr. Wohns serves as chief consultant to Symbion for outpatient spine surgery center development.This article was published in the AANS Neurosurgical Blog and is reproduced here with the author's permission—Ed.)

Ambulatory Surgery Centers Provide Excellent Setting for Spine Surgery

Richard N.W. Wohns, MD
Associate Clinical Professor of Neurological Surgery
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Seattle, WA

It is well known that ambulatory surgery centers (ASCs) provide surgical services at costs lower than hospitals — due in large part because ASCs typically limit their procedures to simpler, lower-risk, ambulatory procedures. In a controversial leap forward, starting in 2015, the Centers for Medicare and Medicaid Services (CMS) approved several new spine surgery codes that neurosurgeons can perform at an ASC. These include:

- Cervical spine fusion
- Lumbar spine fusion
- Spine fusion extra segment
- Cervical spine disc surgery
- Laminectomy single lumbar
- Removal of spinal lamina
- Decompression spinal cord

The result is that many healthy, presumably younger, Medicare patients can opt to have their surgeries at a surgery center, rather than having to go to the hospital. Medicare's approval of these cases opens the door for more commercial payers to reimburse for these procedures when they are performed at ASCs as well. Some payers in particular regions of the country have been reluctant to approve spine surgery in ASCs — even with available cost effectiveness and quality data — because they base reimbursement on Medicare's payment policies.

Since 1994, pioneering neurosurgeons gathered and published data on outcomes and cost differentials for spine surgeries in the ASC and hospital, leading a radical change in how nearly all spine care is delivered. Just a few decades ago, the typical patient undergoing removal of a herniated disc (lumbar microdiscectomy) might remain on bed rest for several days and in the hospital for a week or longer. Today, the vast majority of these cases are done on an outpatient basis with a rapid return to normal activity. The recent CMS ruling now makes all the benefits of outpatient spine surgery available to Medicare beneficiaries.

With experience, we anticipate these changes will lead to further efficiencies and quality in neurosurgical interventions. Consider the following:

- Medicare patients will not be relegated to hospitals and thus will experience fewer surgical infections;
- The entire healthcare delivery system benefits due to lower cost of spine surgeries, which are increasingly necessary for aging baby-boomers — a demographic that wants to remain active; and
- Medicare patients can be operated on in the ASC, without taking up space in the hospital operating room, which blocks access for patients who require a hospital setting for surgery.

As more patients are treated in ASCs, here are a few key trends worth watching in the short and long term:

- Increased overnight stays at the ASC;
- Increased need for outpatient rehabilitation or recovery care;
- More stringent contingency plans for Medicare patients that end up needing a higher-level of care in the hospital; and
- Further expansion of spine surgery in ASCs.

CMS has finally recognized the safety, improved patient satisfaction, and cost-effectiveness of the ASC setting for spine surgery, which many neurosurgeons have recognize for years.

Reference:

1. Wohns, RNW: Safety and Cost-Effectiveness of Outpatient Cervical Disc Arthroplasty. Surgical Neurology International, www.surgicalneurologyint.com/content/1/1/77, 2010

CANS MISSION STATEMENT

'An organization of Neurosurgeons to promote the professional education and scientific achievement of surgeons and quality care for Californians'

Brain Waves

Deborah Henry, MD, Associate Editor

This past Saturday, I spent three hours at the Lyon Museum near John Wayne airport in the company of my family and Sergeant George Emerson, a tail gunner in a B-17 that flew over Germany in WWII. He is now 90 years young, a father of five, grandfather of more, and as a docent in the museum, shares his phenomenal knowledge of a time whose history is slowing leaving those of us still present. As his plane was flying in formation over Eisenberg, Germany in February of 1945, a B-17 above collided with them and their plane was sheared just proximal to the tail gunner position. Mr. Emerson lost consciousness, but he had the foresight to always fly with a portion of his parachute attached. He survived with a head laceration, whose scar is visibly etched on his forehead, and was interned in a German POW camp. Liberation occurred two months later only for him to be sent to a cell camp for interrogation. Among the treasures of this museum in addition to Mr. Emerson and the other WWII vets that peruse the museum is a collection of Duisenberg cars in mint condition. According to one museum sign, the cars cost up to $25,000 during a time when the average doctor earned $3000 a year. Needless to say, only the very wealthy owned one. Each car was designed specific to its new owner's desires. A gorgeous navy blue one had a special door to a compartment design to hold golf clubs.

For long time golf and doctors were symbiotic. I grew up thinking that all doctors took Wednesday afternoon off to play golf. In my practice in Pasadena, this was true among one neurosurgeon. When I google "golf and doctors" a commentary comes up from *Physician Money Digest* stating that "in pop-culture, golf, doctors and money often go together." Yahoo answers states that the average golfer is white, aged and wealthy; the average doctor, the same. As doctors, we know that this once was true of our profession, but no longer. It seems to still be true of golfers.

My dad golfed until he could no longer swing the club effectively. I started "playing" golf because of my ex and my dad. It gave me something to do with them. Father's Day always brings about these memories of playing 18 holes with my dad even when he had to wait for me to 3- (or 4) putt. When I was near the end of my second trimester of pregnancy and was on a course that did not allow carts off of the cart path, my dad went and got a handicap flag. I truly think that this was more for his benefit than mine. We played in an AANS Charity golf tournament in San Antonio with a celeb that hit off of a tee that was a short pencil. Mostly, I wish my dad was there when I hit my one and only hole-in-one, something that he never achieved despite his life-long desire to do so.

When I started playing golf, I would often whiff at the ball. Initially my dad thought I was practicing my swing until he realized that I was just striking out. Later, he sent me an article, probably from Golf Magazine, with no byline that goes "Remember, golf is not brain surgery. It's harder. A person can actually learn brain surgery. A person can never really learn golf. There are 4501 brain surgeons in the U.S. with a median income of $500,000. There are about 50 golfers in the U.S. that make $500,000 or more. On a brain surgeon, it's the eyes that usually go first. On a golfer, the brain can pretty much go any day of the week…. On bad days, a brain

surgeon may sit back and dream about retiring to play golf. On bad days, which can occur anytime, a golfer may sit back and dream about visiting a brain surgeon…."

Here's to all the father-doctors and those fathers that golfed with their daughters and sons. May you have your hole-in-one. And when you are in Orange County, be sure to visit the Lyon museum and spend time with a veteran. What George did was harder than brain surgery too.
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Transitions in Neurosurgery

John Bonner, MD, Associate Editor

At the AANS meeting this past May, 2015, psychiatrist and political commentator Charles Krauthammer noted some of the deleterious changes in the practice of medicine. Krauthammer commented that in the 1970s, many physicians believed that they would have considerable achievement in their professional lives. However, some physicians do not share such a sanguine outlook for the practice of medicine in the current medical climate. The change, says Krauthammer, has been vocational – incessant interference with the practice of medicine, deep erosion in physician autonomy and authority, and a transformation from physician to "provider". Now, according to Krauthammer, there is a never-ending attack on the practice of medicine from the government, insurance companies and lawyers, progressive intrusion, and (usually) unproductive rules and regulations.

One example of such problems is the mandated conversion from paper records to Electronic Health Records (EHRs). There is particular bitterness among physicians over the EHR mandate. Specifically, many physicians have found that the mandate for EHRs has created more need for documentation and has caused a one-quarter (1/4) decrease in the number of patients usually seen, which is frustrating to physicians. A study in the American Journal of Emergency Medicine found that ER physicians spend about 43% of their time entering electronic record information and 28% of their time with patients. Another study found that family physicians spend about 48 minutes a day just entering clinical data. (EHRs require more than billing and legal documentation of patient problems.) The expected cost savings for the future have not materialized, and have actually been wasted, according to Krauthammer. Nonetheless, physicians who do not shift to EHRs will be punished. If EHRs are not in place, Medicare payments will be reduced by 1%, a percentage that rises to 3% in subsequent years (with a potential 5% cut in the future). Krauthammer concluded that the EHR process has resulted in financial waste and patient care degradation, which has demoralized good physicians.

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For more than a century, researchers believed that the body's immune system has had the potential to fight cancer. Today, immunotherapy is emerging as a possible successful

treatment of cancer as the immune system has become the fourth pillar of cancer treatment (alongside surgery, radiation and chemotherapy). Now there are dozens of studies underway in hopes of success for bladder cancer, Hodgkin's Lymphoma, and head and neck tumors. The results have been promising, although the treatments may be expensive (some as much as $10,000 per dose).

For example, one study reported the success of a patient diagnosed with advanced kidney cancer. Initial treatment included removal of the kidney tumor; but the tumor recurred only months later, with liver and lung metastases. This patient was advised that he had only months to live. This patient sought treatment with oncologist Nizar Tammir, M.D. of the MD Anderson Center. Dr. Timmar recommended immunotherapy infusion. After four infusions over 8 weeks, the patient's tumors shrunk by 50-60%. Indeed, after the first infusion, the patient's fever, pain, night sweats, weight loss and anemia were gone. Two years later, this patient is healthy – so much so, that Dr. Tammir is considering stopping treatments altogether.

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Sadly, I note the passing this past June of my neurosurgical mentor and friend, Sean Mullan, M.D., B.Ch., B.A.O., D.So, F.R.C.S., F.A.C.S., and Professor Emeritus of Neurosurgery at the University of Chicago. He was 91 years old. (Some may remember Dr. Mullan who spoke on "Some Neurosurgical Fossils" as the 2010 Cloward Award recipient at the Western Neurosurgical Society Meeting in Santa Fe, New Mexico.)

A pioneer in the field of neurosurgery, Dr. Mullan had a distinguished career. He developed multiple neurosurgical procedures, published over 180 papers and 30 book chapters, and provided what was then the standard neurosurgical textbook, *Essentials of Neurosurgery for Students and Practitioners*. He was President of the Society of Neurological Surgery in 1985, with multiple services for the World Federation of Neurosurgical Societies (he was named the Honorary President for the World Federation of Neurosurgical Societies). He was the first recipient of the Herbert Olivecroma Award from Sweden's Karolinska Institute in 1976; he was the Penfield Medal of Canada in 1979; and he was given the Jamieson Medal of Australia in 1980.

Dr. Mullan was from Northern Ireland and received his neurosurgical medical education in Belfast, in London, and at the Montreal Neurosurgical Institute. Dr. Mullan became a faculty member at the University of Chicago in 1955, joining another mentor of mine, Joseph Evans, M.D., Ph.D. (Dr. Evans came to Chicago with a very pleasant and knowledgeable surgical nurse, Vivian. Vivian and Dr. Mullan were married in 1959.) In 1961, Dr. Mullan received the McClintock Teacher's Prize at the University of Chicago. Dr. Mullan was Chief of Neurological Surgery at Chicago from 1967 to 1992. In addition, Dr. Mullan was a visiting professor in Sweden, Australia, New Zealand, South Africa and Lebanon. He retired from practice in 1992.

We will miss him.

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Not surprisingly, the *Wall Street Journal* reported that hospitals have been disappointed with the results of the Affordable Care Act (ACA). (*Wall Street Journal*, June 3, 2015.) According to the

Wall Street Journal, the ACA hasn't benefited non-profit hospitals in those states that were expected to benefit (WSJ, citing Moody's Investment Service). While performance improved across the board, including in those "red" (mainly Republican) states that opted-out of the law's Medicaid expansion (as the economy improved last year and unemployment declined), hospitals in those "blue" (mainly Democratic) states that expanded Medicaid did not see many positive results. These blue state hospitals expected to benefit from fewer unpaid bills and more paying customers. However, this hasn't translated into better or greater margins or cash flow. In those states that expanded Medicaid, hospitals' unpaid bills fell 13% in 2014 compared with 2013. But the 2014 operating margin did not increase any more than the hospitals in those 22 states that sat out of the expansion. ❖

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!

Tidbits from the Editor

CURES needs a Cure

The California Medical Association (CMA) has noted that the California Department of Justice has recently announced that accessing the new version of the Controlled Substance Utilization Review and Evaluation System (CURES) will require Internet Explorer version 11, Firefox or Chrome Internet browsers. DOJ has indicated that, effective July 1, users of Internet Explorer 10 or earlier will not be able to access CURES. There will be no backward compatibility to earlier versions of this browser. This change will cut off controlled substance prescribers with health information technologies that require use of older versions of Internet Explorer. CMA has estimated that a minimum of thousands of California physicians will lose access to CURES.

Somehow it is hard to be optimistic that the DOJ will perform this run-out well even when we docs have funded the improved database they promise. Fortunately, unless you dispense medications in your office, you need not access CURES unless you want to since the state referendum last fall that would have required us all to consult CURES every time we prescribe a controlled substance failed. The database may also not be as up to snuff as might be expected since pharmacists, who have to enter every controlled substance prescription into cures, are not mandated to do it when they fill the prescription and may well do there CURES entries at the end of the day or week which would make the CURES info silent on an active doctor shopping patient.

CMA recommends that you assess your current capabilities to use one of the supported browsers. While it may be possible for some to simply update or switch to one of the supported Internet browsers, some electronic health record (EHR) systems are incompatible with the supported Internet browsers. You may want to consult with your IT professional or EHR vendor to assess your options

for ensuring continued EHR viability and access to CURES if the updated system is implemented by DOJ on July 1. Another issue is the new Windows 10 to be released on July 29th which can be downloaded and installed for free if you are running most versions of Windows 7 and Windows 8. The new windows 10 will replace Internet Explorer with a new browser called Microsoft Edge which the DOJ is unlikely to even know about much less embrace.

An alluring option is to do nothing until the dust settles on this whole mish-mash.

MICRA challenge Fails

The CMA reports that on June 9, the California Court of Appeal based in San Francisco issued its precedential opinion in *Chan v. Curran*, fully upholding various provisions of California's landmark Medical Injury Compensation Reform Act (MICRA) against constitutional attacks by California's trial attorneys.

The plaintiff had argued that the MICRA cap on non-economic damages violated her constitutional rights to equal protection, due process and trial by jury. In this published opinion, the Court of Appeal characterized all of Chan's arguments as "ultimately grounded on the assertion she is entitled to seek non-economic damages sufficient to cover attorney fees." This was a novel twist that the trial lawyers came up with – to argue that the MICRA cap essentially deprived injured plaintiffs of their day in court because few attorneys would take on contingency cases subject to the $250,000 cap on noneconomic damages.

The court went on to reject each and every one of Chan's constitutional arguments. It observed that California courts have consistently rejected constitutional attacks on MICRA because they are contrary to well-established legal principles for determining the constitutionality of economic and social welfare legislation under the extremely deferential rational basis test. The court discussed previous California Supreme Court cases upholding section 3333.2 and other MICRA provisions against similar constitutional challenges. The court also rejected Chan's argument that MICRA's constitutionality should be reexamined due to "changed circumstances" in today's medical malpractice insurance climate; the court held that she failed to demonstrate that the circumstances leading to MICRA's enactment no longer exist.

The court acknowledged that MICRA may inhibit medical malpractice plaintiffs from finding counsel willing to accept cases on a contingency basis, but concluded that that result did not offend due process. Finally, the court held that the Supreme Court and other Courts of Appeal had previously considered and properly rejected Chan's argument that MICRA infringed on the right to a jury trial. ❖

Opinion for the Month:

I WAS SPANKED AS A CHILD AND NOW SUFFER FROM A PSYCHOLOGICAL CONSEQUENCE. IT IS CALLED: "RESPECT FOR OTHERS".

Meetings of Interest for the next 12 months:

Western Neurosurgical Society: Annual Meeting, September 10-13, 2015, Kauai, HI
CSNS Meeting, September 25-26, 2015, New Orleans, LA
Congress of Neurological Surgeons: Annual Meeting, September 26-30, 2015, New Orleans, LA
North American Spine Society: Annual Meeting, October 26-29, **2015,** Boston, MA
California Neurology Society: Annual Meeting, November 13-15, 2015, San Francisco, CA
AANS/CNS Joint Pediatric NS Section: Ann. Meeting, December 8-11, 2015, Seattle, WA
Cervical Spine Research Society: Annual Meeting, December 3-5, 2015, San Diego, CA
North American Neuromodulation Society: Ann. Meet., December 10–13, 2015, Las Vegas, NV
CANS Annual Meeting, January 22-24, 2016, The Cliffs Resort, Pismo Beach, CA
AANS/CNS Joint Cerebrovascular Section: Annual Meeting, 2016 TBA
Southern Neurosurgical Society: Annual Meeting, March 2-5, 2016, San Antonio, TX
AANS/CNS Joint Spine Section: Annual Meeting, March 16-19, 2016, Orlando, FL
Neurosurgical Society of America: Annual Meeting, June 19-26, 2016, Dublin, Ireland
CSNS Meeting, April 29-30, 2016, Chicago, IL
AANS/CNS Joint Pain Section Bi-Annual Meeting**, April 29, 2016,** Chicago, IL
AANS: Annual Meeting, April 30-May 4, 2016, Chicago, IL
Rocky Mountain Neurosurgical Society: 2016 Annual Meeting, TBA
New England Neurosurgical Society: 2016 Annual Meeting, TBA
AANS/CNS Joint Neurotrauma and Critical Care Section 2016 Meeting**, TBA**

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. Phillip Kissel 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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