CANS newsletter

SAVE THE DATE

The 43rd CANS ANNUAL MEETING

Friday, January 22nd – Sunday, January 24th

The Cliffs Resort, Pismo Beach, CA

"Regaining Patient Choice and Physician Freedom"

President's Message

Phillip Kissel, MD, CANS President

What is the CSNS? This seems to be a simple question but as with many organizations there are multiple levels. The fall meeting was recently held in New Orleans and was well represented by CANS attendees. I had the privilege to serve as chairperson and present a summary of our upcoming annual meeting plans. The purpose of this message is to share my observations and impression of the current Council of State Neurosurgical Societies.

The CSNS has a history that dates to its first meeting at O'Hare airport in 1973. Two of the three advisory neurosurgeons were from California, Dr. Edwin Aymes and Dr. George Ablin. Working in conjunction with the parent organizations (AANS & CNS) this nationwide group of physicians formalized the elected state delegate concept. The name Council of State Societies was adopted with Ed Amyes being the chairman overseeing its first meeting in 1978. A comprehensive review of the organization's history has been originally compiled by our own Randy Smith and recently updated by Dr. Clarence B. Watridge. I had the pleasure of listening to Dr. Watridge as he reviewed this rich history with the newcomers at the fall meeting. Anyone interested in the full story would be referred to the CSNS website csnsonline.org/history.

The CSNS is a freestanding organization that believes neurosurgeons are their patients' strongest advocates, and the specialty of neurosurgery stands for the highest quality of care. The purpose of The Council is to:

1. Positively influence and affect the socioeconomic policy of organized neurosurgery for the benefit of neurosurgical patients and the profession.
2. Serve as a resource for socioeconomic knowledge and education for neurosurgeons, regulatory and health care officials, and legislative representatives.
3. Provide a conduit for new initiatives, concerns, and issues to be brought to the AANS and CNS for response and action.
4. Provide an environment for developing future leaders in healthcare policy and advocacy for neurosurgery.

This is a representative, deliberative, and collaborative organization of delegate neurosurgeons in training and a diversity of clinical practices. It is inclusive of all practice models and open to all neurosurgeons. There are no annual or individual meeting fees.

INSIDE THIS ISSUE:

This is a very focused group of concerned and intelligent practitioners. They come together twice a year and share knowledge and experience as it relates to the constraints of neurosurgical practice in this country. The meeting is extremely efficient. The current president, Dr. Ann Stroink did a superb job and is currently my personal hero. We are fortunate that she will be joining us at the upcoming CANS Annual meeting in January to participate as a panel member representing private practice.

The exchange of ideas has a unique blend of being formal and parliamentary but retains open avenues of free flowing discussion. Anyone who chooses can be involved with his or her respective Quadrant group, a subcommittee, or by simply stepping up to the microphone. Retirees to residents, and even medical students, are an integral part of the meeting. It is truly a gathering of like minds with aligned aspirations and goals.

Lastly, the CANS organization continues to play a pivotal role in the CSNS. They look to us as the tip of the spear as many of the socioeconomic changes are tested in California. It remains imperative that we continue to support and contribute to this vibrant Society. ❖

HIPAA and Sign-in Sheets

Randall W. Smith, MD, Editor

Our friend Jeff Segal at *Medical Justice* points out that a lot of the sign-in sheet paranoia about revealing protected health information isn't necessary, particularly for the average neurosurgeon. Here is his and his consulting attorney's take on the issue:

THE PROBLEM*--My partner says that because of HIPAA we can't have a sign-in sheet at the front desk. Even if it is not left out, the next patient can still see the names of the prior sign-ins when it is handed to them for them to sign in. This is making it harder for the admin to track patients and for us to follow how we are doing in terms of seeing patients on schedule. So now everyone is annoyed.*

THE ANSWER*--HIPAA requires you to take reasonable precautions to minimize the release of Protected Health Information (PHI) in the course of your office's work. But it does not require absolute confidentiality because that would make it literally impossible to function. So it all depends on what your sign-in sheet says. A medical fact only becomes PHI when it can be identified as being associated to a given patient. As long as the sheet only lists the name and time, only the most minimal PHI is revealed – that that person is a patient of yours. It is the written equivalent of seeing the person come in the door or sitting in the waiting room but knowing nothing else about them other than that they are there to see you. That level of disclosure is seen as merely incidental to medical care and generally not considered a HIPAA violation.*

Taken together with not leaving the sign-in sheet out (but given out only when a patient is actually signing-in), recording only the (full) name and time will more than satisfy HIPAA's requirement that you limit even incidental exposures of PHI.

But, if you have a practice in a sensitive area of medicine, such as high-risk pregnancies or oncology, in which just the fact that the patient is your patient speaks volumes about their medical issues, then you could switch to just logging patients into the computer and skip the sign-in sheet. This will still let you do the tracking you need without any disclosures at all other than to staff. ❖

CANS MISSION STATEMENT

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

Brain Waves

Deborah Henry, MD, Associate Editor

A couple of days ago, I needed to get into a men's restroom. I was walking around my college campus with the Vice-President of finance (a woman) to see if we could revise a laboratory and use part of the space in the restroom occupied with urinals. Having accidentally walked into men's restrooms more than once in the past, I wasn't too shy about entering. So the experience a couple of days ago reminded me of one of my most memorable "accidents."

It must have been about 2am when as a naive junior resident I was called to the local community hospital to evaluate a patient. The patient ended up requiring an operation, so I headed to the operating room to remove my white coat and store my possessions in a locker. I darted into a huge room with floor to ceiling lockers, marble floors, spacious sitting areas, and immediately I knew I was in the wrong place. Inaudibly, I slipped out before catching the eye of anyone with a Y chromosome while all the time wondering how I made this mistake. As I departed, I glance at the sign at the entrance, and it clearly said "Doctors". It was then that I realized I simply went to where my early morning foggy-brain directed me: the Doctors room (yes, I was a doctor) instead of the Nurses room. Stealthily, I crept into the nurses changing room where I crammed my coat and possessions into a 3 by 1 locker and sat on a narrow bench to stretch on my blue booties.

The first time I saw a doctor's locker room for women, I was in Texas. It was in an after-thought room with same 3 by 1 lockers, a small bench for sitting and a handicap restroom. But empty of the cacophony of chattering women, it was so quiet. Perhaps there were three of us women doctors total: a general surgeon, an anesthesiologist, and myself.

The second time I saw a doctor's locker room for women was Arcadia Methodist Hospital in California. It too was in a forgotten corner of the operating room floor, and like the room in Texas, had no direct access to the operating room. But both changing rooms offered a bit of respite for us women entering very male-dominated fields, and despite their far-off location, their miniscule size, their lack of marble floors, and spacious sitting areas, they were a way of saying we were wanted. I haven't wandered into a male changing area, doctor or not, since that day in residency, so I don't know if the marble floors have gone into oblivion like of many hospital physician dining areas. I suspect that they may still be inequality in the furnishings between the men and women locker rooms, but at least I haven't seen Doctors for the men and Nurses for the women since that fateful day in residency. ❖

Trasitions in Neurosurgery

John Bonner, MD, Associate Editor

One in three Californians, or 12.3 million people, are now enrolled in Medi-Cal. A key issue with Medi-Cal is access of patients to medical care providers. The Maddy Report this Sunday, September 27, 2015, aired a television program on the problems of providing healthcare to Medi-Cal patients. The California Auditor General, Elaine Howle, was the guest on the program, and she recited the deficiencies in oversight by the California Department of Health Care Services and, for rural counties, by the California Department of Managed Care. Specifically, the Auditor General's 2015 Report found that the Medi-Cal provider directories (issued by Medi-Cal insurers, such as Anthem Blue Cross and HealthNet) were inaccurate, and that the "Ombudsman" established for consumer complaints and assistance can only handle 30-50% of the 32,000 to 71,000 calls it receives per month. According to Auditor General Howle, there is little-to-no oversight in terms of ensuring the accuracy and adequacy of insurance plans for Medi-Cal patients. To further complicate matters, the Department of Health Care Services and the Department of Managed Care are understaffed and use an antiquated phone system (where data is lost every time the system crashes).

According to the Maddy Report, the number of individuals on Medi-Cal has expanded dramatically, yet there is not enough administrative staffing assistance to help people find health care providers. Before being certified, AG Howle asserted, a healthcare plan (e.g., Anthem Blue Cross) should be providing accurate directories that give Medi-Cal patients appropriate access to healthcare professionals (i.e., a provider within 10 miles or 30 minutes, that has a patient volume of less than 2,000 "beneficiaries" or patients per provider). While the Department of Healthcare Services stated that they found no errors in the accuracy or adequacy of the insurance companies' directories of healthcare providers, the California Auditor General's Office reported that it did find errors in the adequacy and accuracy of the Medi-Cal provider directories (e.g., the Auditor General's Report noted that there was a 23.4% error rate in my home county of Fresno -- that's an error rate of nearly 1 in 4 provider listings).

The California Department of Healthcare Services contracts with the California Department of Managed Care for oversight of providers in the 28 rural counties in California. According to the Maddy Report, although the Department of Managed Care is required by law to perform a quarterly assessment of provider plans (again, for accuracy and adequacy of providers for patients on Medi-Cal), no assessment at all has been done yet for these 28 rural counties (that's no assessment in the several years since the ACA passed).

In sum, the access to, and adequacy of, healthcare for some of California's most vulnerable communities (low-income and disabled persons relying on Medi-Cal) is woefully deficient, while at the same time there is little-to-no avenue for assistance to those seeking help in finding care by attempting, with no assurance of success, to contact the understaffed ombudsman via an antiquated phone system. Indeed, on average 12,500 patient calls per month fail to reach a live person, so a patient may be frustrated in their effort to seek help in finding a Medi-Cal provider (the Maddy Report did say that the phone system is being updated to be able to handle more calls, but that appropriate staffing and workload levels need to be established by both the California Department of Healthcare Services and the California Department of Managed Care).

===

Competition among physicians and hospital systems is not uncommon or necessarily of significant concern. Unfortunately, there can be occasion for problems with competing hospital or physician services. Such is the case in Fresno where local hospitals that once complimented the others' pediatric services now are in direct competition.

Fresno Community Regional Medical Center, which has long been affiliated with UCSF, used to have a relationship with Children's Hospital of Central California, which provided healthcare to children of the San Joaquin Valley. However, a "falling-out" occurred between the two facilities. Subsequently, Children's Hospital of Central California became (actually it reverted back to its old name), Valley Children's Hospital. Upon its breakup with Community Regional Medical Center, Valley Children's Hospital initiated a relationship with Stanford University. Community Regional Medical Center maintains that it will still provide children's healthcare, despite losing its association with Valley Children's Hospital. How well two local, once-allied hospital systems -- now in direct competition -- can provide pediatric healthcare to children of the Central Valley remains to be seen. ❖

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!

ATTENTION EXHIBITORS

Has your company signed up to exhibit for the

CANS 43rd Annual Meeting?

Hurry, SPACE IS LIMITED!

See attached exhibitor packet

Contact: Emily@cans1.org or 916.457.2267

Tidbits from the Editor

ICD-10 Come Hell or High Water

Congressional Quarterly reports that the nationwide transition to ICD-10 will proceed on Oct. 1 "even if Congress triggers a partial government shutdown that day by missing an appropriations deadline, according to a top federal official." Patrick Conway, principal deputy administrator of the Centers for Medicare and Medicaid Services, said the agency is already establishing contingency plans for handling the switch if the government is shut down. Managing the transition "is among the top priorities for the agency, and CMS has some flexibility in its staffing that can be used to keep the work on track in case of a shutdown, he said."

Work Comp to Require ICD-10

The California Division of Workers' Compensation has posted final regulations on the transition to the 10th edition of the International Classification of Diseases on Oct. 1.

The regulations include updates to the Doctor's First Report of Injury (Form 5021), the Primary Treating Physician's Progress Report (Form PR-2) and the Primary Treating Physician's Permanent and Stationary Report (Forms PR-3 and PR-4).

Although the regulations take effect Oct. 1, they provide a grace period for use of the revised forms. From Oct. 1 to Dec. 31, providers may use either the new or old versions. For services rendered on or after Oct. 1, the ICD-10 code is required whether the old form is used or the new. The new forms will be required for all services rendered on or after Jan. 1.

Like the CMS leeway rules for Medicare billing, the Work Comp rules also include some "leeway" aimed to prevent bills from being rejected simply because medical providers are not yet familiar with ICD-10 codes. The DWC said the rules state that a bill shall not be denied solely due to the "level of specificity" in the selection of the ICD-10 code as long as the diagnosis code used the valid ICD-10 number.

Congressional bill excluding ASC's from MU requirements goes to POTUS

Medscape Medical News reports that the US Senate unanimously passed a bill that would protect physicians who work in ambulatory surgery centers (ASCs) from being financially penalized by Medicare for not showing meaningful use of electronic health records (EHRs). The Electronic Health Fairness Act of 2015, which was previously approved by the House, is now awaiting President Barack Obama's signature.

The measure addresses a blind spot in the Health Information Technology for Economic and Clinical Health Act of 2009. That law requires eligible professionals to use certified EHR technology (CEHRT) in at least 50% of their patient encounters to meet the requirements of meaningful use.

With more than 5300 ASCs in the United States performing 23 million surgeries annually, the problem for physicians who work in ASCs is that those facilities do not have the certified EHRs that are required to show meaningful use. With all patient encounters in an ASC counting against a doctor's 50% threshold, it is likely that ASC doctors will be subject to penalties for not showing meaningful use. The Electronic Health Fairness Act exempts patient encounters in ASCs from the requirement that physicians use a certified EHR for 50% of all patient encounters.

Young Neurosurgeons with Med School Debt can Save

In 2013, more than 80 percent of physicians under the age of 40 were still are paying off their medical school loans, according to the AMA Insurance's National Work/Life Profiles 2013 survey. Nearly one-half of these young physicians were carrying a debt of $150,000-$200,000. You might consider loan refinancing your medical school loans.

Student loan lenders will buy out your loans—public and private—from you existing servicers, allowing you to have one new loan at a potentially lower interest rate. This process also will consolidate all of the loans you refinance into one payment. The average physician can save around $40,000 by refinancing.

To get the best offer you should:

- Be in good credit standing
- Have a low debt-to-income ratio
- Have work experience
- Be aware of current market rates
- Apply with a cosigner
- Compare multiple offers

Traditionally, you would need to find multiple lenders, submit an application to each lender and sift through offers to determine which you think is best. AMA members have access to Credible Labs, a student loan refinancing group endorsed by the AMA MVP Program.

With Credible, you can check to see whether you're paying too much for your existing loans as compared to your peers. If you are, complete a single form on Credible's website and you'll receive personalized offers from multiple lenders. Credible allows you to compare all offers side-by-side to see which works best for you. AMA members who use Credible can receive refinancing offers as low as 1.93 percent APR and get a $420 bonus.

Final Resolution Disposition at CSNS Meeting September 25-26, 2015

RESOLUTION I
Title: INCLUSION OF A PATIENT IMPACT ASSESSMENT ON CSNS RESOLUTIONS
Action: Rejected
BE IT RESOLVED, that all resolutions submitted to the CSNS carry a "Patient Impact Assessment"; and
BE IT FURTHER RESOLVED, that the Patient Impact Assessment of a CSNS resolution comments upon the anticipated effect the resolution will have on neurosurgical patients if its requested action is seen to fruition; and
BE IT FURTHER RESOLVED, that a CSNS resolution author(s) is prepared to discuss the patient impact of the resolution in open testimony at the CSNS plenary session.

RESOLUTION II
Title: Making connections between graduating residents and state societies
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS send a list of State Society contact information to graduating residents, and
BE IT RESOLVED, that the CSNS work with the AANS and CNS to contact neurosurgeons transitioning from provisional to full membership of those associations regarding participation in their state societies.
BE IT FURTHER RESOLVED, that an information letter will be crafted by the CSNS Chair and will outline value of participation in state neurosurgical societies and will contain contact information for state societies.

RESOLUTION III
Title: "Integrated care pathways" for Neurosurgeons in the Era of the Affordable Care Act
Action: Refer to Executive Committee
BE IT RESOLVED, that the CSNS will investigate the extent to which "Integrated Care Pathways" are being implemented in neurosurgical practices, including the impact of these pathways on practice, and will report the findings in a white paper; and

BE IT FURTHER RESOLVED, that the CSNS create content that describes and explains the practical creation, validation and acceptance of an "Integrated Care Pathway" with relevance to clinical neurosurgery geared towards the busy practicing neurosurgeon and make available such content to both the CSNS membership and neurosurgeon members of the AANS and CNS.

RESOLUTION IV
Title: CSNS resource to access and dispute Physician Payments Sunshine Act Data
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS will post a link to the Open Payments website on the CSNS website providing neurosurgeons access to their data in order to encourage and accommodate early review and timely disputing; and
BE IT FURTHER RESOLVED, the CSNS work with the Washington Committee to update the existing open payments reference document and a link will be posted on the CSNS website.

RESOLUTION V
Title: Assessing the impact of ICD-10 on neurosurgical practices and patient access to neurosurgical care
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS will measure the impact of ICD-10 implementation by conducting a survey in two phases in collaboration with NERVES, that will be administered to the AANS, CNS, CSNS and NERVES membership, and that this survey will measure such factors as outpatient clinical volumes, surgical volumes, number of days of account receivables, charge lag, collections, denials, and cash flow; and
BE IT FURTHER RESOLVED, that an update of available data be given at the Spring 2016 Meeting and a subsequent white paper summarizing the finding of the surveys will be drafted and made available to AANS and CNS members.
BE IT FURTHER RESOLVED, that a white paper summarizing the finding of the surveys will be drafted and distributed to AANS, CNS and CSNS members.

RESOLUTION VI
Title: Evaluating the impact of the medical review panel process on neurosurgical malpractice litigation
Action: Adopted Resolution
BE IT RESOLVED, that by the 2016 Spring CSNS meeting, the CSNS will assess the effectiveness of the medical review panel process in preventing frivolous litigation pertaining to neurosurgery only, and
BE IT FURTHER RESOLVED, that if the medical review panel process is found to be helpful in protecting neurosurgeons against frivolous litigation, then the CSNS will formulate a statement of support /recommendation that the medical review panel process should be adopted in all 50 states.

RESOLUTION VII
Title: Expansion of Non-delegate, non-appointee participation in CSNS activities
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS Rules and Regulations Committee draft amendments to the rules and regulations that modify the description of the NDNA category to the positive descriptor "Affiliate"; and
BE IT FURTHER RESOLVED, that the new class of affiliates (NDNA members) of the CSNS are granted appropriate website access and other administrative support to facilitate their participation in the CSNS.
BE IT FURTHER RESOLVED, that a standard operating procedure be developed for the inclusion and participation of affiliate CSNS members.

RESOLUTION VIII
Title: Development of new quality reporting measures
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS establish a web based tool accessible to all neurologic surgeons that will aid in the identification of quality measures applicable to neurologic surgeons; and

BE IT FURTHER RESOLVED, that the CSNS offer to work with the AANS and CNS, and work, in particular, with the Neurosurgical Quality Council to identify quality measures specific to neurosurgical participation in MIPS/PQRS.

RESOLUTION IX
Title: Assessment of the Impact of Mobile Technology in the Neurosurgical Operating Room
Action: Substitute Resolution referred to the Executive Committee
BE IT RESOLVED, that the CSNS develop a white paper to study the issue of social media and mobile technology use in the neurosurgical operating room and other patient care areas; and
BE IT FURTHER RESOLVED, that the CSNS request that the parent organizations develop a position statement on the use of social media and mobile technologies in the neurosurgical operating room; and
BE IT FURTHER RESOLVED, that the CSNS provide our parent organizations with three work products that can be distributed to members:
1) How can neurosurgeons protect PHI when they use PEDs?
2) Benefits and pitfalls of PEDs in the OR and clinic: What every neurosurgeon should know.
3) Social media guidelines: Best practices for neurosurgeons.

RESOLUTION XI
Title: Neurosurgeon Use of Gadolinium Enhanced Brain MRI
Action: Adopted Amended Resolution
BE IT RESOLVED, that the CSNS request that the parent organizations (AANS and CNS) work with the FDA regarding the appropriate use of GBCA in the assessment of neurological disorders.

Orthopods publish checklists to help docs get Work Comp OK for surgery

The California Orthopedic Association (COA), through their Workers' Compensation Committee, has developed checklists for about 30 orthopedic medical conditions in which treatment plans are most frequently rejected. Ten of these checklists pertain to procedures potentially performed or ordered by neurosurgeons including: Cervical Fusion, Lumbar Discectomy, Lumbar Fusion, Lumbar Laminectomy for Stenosis, Lumbar Laminectomy and Fusion for Degenerative Spondylolisthesis, Fusion for Adjacent Segment Disease, Laminectomy and Fusion for Degenerative Spondylolisthesis, Kyphoplasty, Facet Joint Injections and Lumbar Epidural or Selective Nerve Steroid Injection. They recommend sending the completed checklist along with the request for authorization to the insurance company so when the requests are sent for Utilization Review, as they often are, the UR doc can clearly see that all the i's are dotted and all the t's crossed. They also strongly recommend the requesting surgeon be sure to communicate with the UR doc should they call.

The checklists are available on the COA Website at http://www.coa.org/index.html . ❖

Thought for the Month:

If you have more than you need—build a longer table, not a higher fence.

Meetings of Interest for the next 12 months:

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: Ann. Meet., February 15-16, 2016, Los Angeles, CA
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
Western Neurosurgical Society: Annual Meeting, September 9-12, 2016, Carlsbad, CA
CSNS Meeting, September 23-24, 2016, San Diego, CA
Congress of Neurological Surgeons: Annual Meeting, September 24-28, 2016, San Diego, CA

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.

CANS Board of Directors

President	Phillip Kissel, MD	San Luis Obispo	
President-Elect	Praveen V. Mummaneni, MD	San Francisco	
1st Vice-Pres	Kimberly A. Page, MD	Redding	
2nd Vice-Pres	Kenneth Blumenfeld, MD	San Jose	
Secretary	Patrick R.L. Rhoten, MD	Beverly Hills	
Treasurer	Marshal Rosario, MD	Campbell	
Immed Past Pres	Deborah C. Henry, MD	Newport Beach	
Past President	Theodore Kaczmar, Jr, MD	Salinas	
Directors			
Northern CA	Ripul Panchal, DO	Sacramento	
	John K. Ratliff, MD	Stanford	
	Mitchel Berger, MD	San Francisco	
Southern CA	Langston Holly, MD	Los Angeles	
	Frank Hsu, MD	UCI	
	Bob Carter, MD	San Diego	
	Farbod Asgarzadie, MD	Fontana	
Consultants	Moustapha Abou-Samra, MD	Ventura	CSNS
	John T. Bonner, MD	Fresno	Newsletter
	William L. Caton III, MD	Pasadena	Past President
	Philipp M. Lippe, MD	San Jose	CAC
	Lawrence M. Shuer, MD	Stanford	Residency Training Programs
	Randall W. Smith, MD	Escondido	Newsletter
	Patrick J. Wade, MD	Glendale	CMA
	Kenneth Ott, MD	San Diego	Past President
	Marc A. Vanefsky, MD	Anaheim	Past President
	Austin R. T. Colohan, MD	Loma Linda	Past President
Historian	Donald J. Prolo, MD	San Jose	

Executive Secretary Emily Schile
emily@cans1.org

This newsletter is published monthly from the Executive Office:

California Association of Neurological Surgeons
5380 Elvas Avenue
Suite 215
Sacramento, CA 95819
Tel 916 457-2267
Fax 916 457-8202
www.cans1.org